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Commonwealth of Virginia Department of Medical Assistance Services

Program of All-Inclusive Care for the Elderly (PACE) Data Book and Capitation Rates Fiscal Year 2016

June 2015

Submitted by:

PricewaterhouseCoopers LLP

Three Embarcadero Center

San Francisco, CA 94111

June 24, 2015

Mr. William J. Lessard, Jr.
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

June 24, 2015

Dear Bill:

Re: PACE Data Book and Capitation Rates – FY 2016

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for Fiscal Year 2016, effective July 1, 2015 to June 30, 2016, for the Virginia Programs of All-Inclusive Care for the Elderly (PACE) that operate as a full PACE program. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services requirements that the capitation rates be developed under guidelines that rates do not exceed the Fee-for-Service Upper Payment Limit, the amount that would be paid by the Medicaid program in the absence of a PACE program, and are appropriate for the population covered by the program.

The development of these rates was overseen by Sandra Hunt, Partner, Susan Maerki, Project Manager, and Peter Davidson, Lead Actuary.

Please call us at 415/498-5365 if you have any questions regarding these capitation rates.

Very Truly Yours,

PricewaterhouseCoopers LLP

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Fiscal Year 2016
Prepared by PricewaterhouseCoopers LLP

June 2015

PricewaterhouseCoopers LLP (PwC) has developed the capitation rates for the Virginia Medicaid Program of All-Inclusive Care for the Elderly (PACE) for State Fiscal Year 2016 for rates effective July 1, 2015. This includes PACE rates for programs operational throughout the state. Rate setting for PACE programs is guided by regulations that limit payment to at or below the amount the Medicaid program would pay as a Fee-for-Service Equivalent (FFSE) cost in the absence of the PACE program; this is also referred to as the Upper Payment Limit (UPL). The methodology presented in this report meets the UPL guidelines and conforms to appropriate standards of practice promulgated from time to time by the Actuarial Standards Board. Rates based on UPL guidelines do not require actuarial certification.

The final rates will be established through signed contracts with the PACE plans, which will ensure that the plans concur that the rates paid will allow for contracting with sufficient numbers of providers to ensure appropriate access to health care and that they expect to remain financially sound throughout the contract period. Capitation rates are developed for a population aged 55 and over and vary by dual eligibility status (Medicaid/Medicare or Medicaid Only). The PACE rates are developed for five regions in the state and will be paid to current PACE operators as well as to any expansion sites.

Medicaid PACE rates include funding for acute care as well as the long term care and personal care services under the Elderly or Disabled with Consumer Direction (EDCD) waiver. Total payments to PACE programs include separate payments from the Medicare program for dual eligibles.

I. Background

PACE programs provide an alternative to nursing home and home and community-based services care for individuals who are certified as nursing home eligible. Originally developed through the On-Lok program in San Francisco, PACE programs are seen as an option to allow nursing home eligible individuals to remain independent by providing a single source for all needed health and social services. To be eligible for PACE, an individual must be at least 55 years of age and certified by the state as eligible for nursing home services. Enrollment in the program is voluntary.

Medicaid programs pay PACE sites a capitated fee designed to cover the full cost of all services required by PACE enrollees that would otherwise be paid through the Medicaid fee-for-service system. A PACE program is capitated for both Medicaid and Medicare covered services. Medicare's contribution to PACE costs is currently set based on the Average Adjusted Per Capita Cost (AAPCC) for the geographic area in which the PACE program operates and is risk adjusted. PACE centers typically enroll 100 to 200 individuals although there are multi-site programs with larger centers. Consequently, it is important that the capitation rates paid for the program provide an accurate estimate of costs for the specific population that enrolls in the program, as there is little ability for PACE programs to accommodate significant variations in the level of health care need of individual participants through high volume.

Our analysis includes data for all individuals eligible to participate in PACE. This includes the nursing home eligible population, both those who are residents of nursing homes, as well as those who are enrolled in Home and Community Based Care waiver program. For the base period, those in the Home and Community Based Care waiver programs were in either Medicaid Fee-for-Service or in the Medallion 3.0 managed care program. As of December 1, 2014, all people in the Elderly of Disabled with Community Direction (EDCD) Home and Community Based waiver are in Medallion 3.0 for their acute care services. All long term care and HCBS are provided through the Medicaid FFS system.

We have implicitly assumed that the distribution of enrollment in a PACE program will mirror the PACE-eligible population. In other words, if 55% of the PACE eligible population is currently residing in nursing homes, the UPLs reported here implicitly assume that 55% of the enrollees would otherwise have been nursing home residents for the base calculation. The rates for these and any new PACE programs is assumed to have the same proportion of residents of nursing homes and Home and Community Based Service waiver programs as the eligible population statewide.

PACE capitation rates

Payments to managed care plans for PACE enrollees are subject to federal rules. As a Medicaid program, the state must comply with federal regulations set by CMS regarding payment levels. Specifically, full PACE programs are subject to rate setting under UPL guidelines. In addition, CMS must approve the payment rates made to each plan. The PACE capitation rates shown in this report are designed to comply with both the CMS definition of actuarial soundness and the UPL. In general, the methodological approach under either guideline can be similar.

Specifically, we have analyzed historical fee-for-service claims for the PACE-eligible population in each region. We then made adjustments to the historical data to reflect modifications of payment arrangements under the fee-for-service program and updated the payment rates to reflect the contract period covered by these rates. We also reviewed financial data provided by the contractor to assess comparability and the reasonableness of the distribution of medical and administrative costs. This financial review provided information used to adjust the

fee-for-service results for expectations of managed care savings and an allowance for PACE plan administrative costs.

II. Data sources

PwC obtained detailed historical fee-for-service claims and eligibility data from the Department of Medical Assistance Services (DMAS) for services incurred and months of enrollment during State Fiscal Years 2013 through 2014 with claims paid through February 2015. The claims in the historical database include Medicaid paid amounts net of any third party insurance payments, which are primarily Medicare payments, and the amounts for which patients are personally responsible for the nursing facility and personal care services. Fee-for-service data are used to develop PACE rates because PACE rate setting guidelines do not permit direct use of encounter data from the contracting PACE plans. In any event, there is insufficient experience from the PACE organizations themselves to use as the basis for rate setting.

The work in this report builds on analyses performed in developing FY 2016 capitation rates for the Medallion 3.0 program. In the Medallion 3.0 program, special adjustments are made to the historical data to reflect changes in payment arrangements due to other programmatic and legislative adjustments; Where applicable, these same adjustment factors are used in the development of the PACE rates.

The claims and eligibility information used in this report includes data for Medicaid recipients who are potentially eligible for the PACE program based on their age, eligibility category, and eligibility for nursing home services. Members eligible for PACE are identified by an indicator on each eligibility record that signifies that the member is in a nursing facility or a Home and Community Based Care waiver. There is one exception to the potentially eligible for PACE criteria. We excluded PACE eligibles who enrolled in the Commonwealth Coordinated Care (CCC) Duals Financial Alignment Demonstration and met the criteria for Nursing Home Eligible–Institution or Nursing Home Eligible–Waiver. Once these duals are enrolled in CCC, the acute and LTC service costs are the CCC Duals plan responsibility and claims information is no longer processed in the FFS data. Because voluntary enrollment in CCC began March 2014 and the first auto-assignment was not until July 2014, the CCC exclusion for the Dual Eligible PACE population had a minor impact on the FY 2013-FY2014 historical base data, but had a greater impact on claims run-out and the evaluation of trend factors.

All claims and eligibility data for members who are not eligible for the PACE program were excluded from the historical data used in these calculations. Members who incurred services indicated as “Nursing Facility/Mental Retardation” are not eligible to enroll in PACE, although they would otherwise qualify for PACE based on this indicator. Another category of members who would qualify for but are unlikely to enroll in PACE are those who receive a high level of special and complex services, such as ventilator assistance. All claims and eligibility periods for both of these groups were removed from the database prior to the calculations shown in this report. PACE eligibles identified in the DMAS eligibility files were also matched to three other data sets. These are 1) mental and behavioral health costs managed by Magellan under an administrative services arrangement that began November 1, 2013, 2) costs associated with consumer-directed personal care services received under the EDCD waiver and 3) acute care costs for the Acute and Long Term Care (ALTC) population enrolled in managed care organizations who continue to receive acute services from their health plan and receive LTC services through Medicaid FFS. The costs for the ALTC population are added to the base for the non-dual PACE eligibles.

Claims and eligibility for retroactive periods (claims incurred prior to a determination of Medicaid eligibility that are ultimately paid by Medicaid) were also removed from the data before summarization because plans are not

responsible for retroactive periods of coverage. Claims are limited to those services covered in the approved state plan.

The resulting historical claims and eligibility data were tabulated by service category for dual and non-dual eligibility status and region and are shown in Exhibits 1a - 1b, which are generally referred to as the "Data Book". The regional data provide an adequate basis for rate setting and no data smoothing techniques are applied. These exhibits in 1a – 1b show unadjusted historical data and are the basis of all future calculations described here. These exhibits show, for informational purposes:

- Member months for Fiscal Years 2013 and 2014,
- Medicaid payment amounts for the combined years,
- Patient payment amounts for the combined years[1],
- Costs per member per month (PMPM) for the combined years (a combination of Medicaid and patient payment amounts),
- Unadjusted units of service for Fiscal Years 2013 and 2014 (a definition of "units" for each category of service is provided in Exhibit 6),
- Annual units/1,000 members for the combined years, calculated as the total units of service divided by the appropriate member months, multiplied by 1,000, multiplied by 12, and
- Cost per unit of service.

III. Capitation rate calculations

The capitation rates for Fiscal Year 2016 are based on the historical data shown in Exhibits 1a – 1b adjusted to reflect changes in payment rates and covered services. Each of the adjustments to the historical data is described in the following section. The adjustments are applied to the historical data and the resulting capitation rates are calculated in Exhibits 4a – 4b.

The steps used for calculating the capitation rates are as follows:

1. The historical data for each Medicare eligibility status and region are brought forward to Exhibits 4a and 4b from the corresponding cell in Exhibits 1a and 1b.[2] This information serves as the starting point for the capitation rate calculation.
2. A number of changes in covered services and payment levels have been mandated by the Legislature or by changes to the Medicaid State Plan. Several of these adjustments were described in the Medallion 3.0 report and applied to the PACE calculations. Additional adjustments that apply to the PACE eligible group are incorporated into these calculations. These adjustments are described in greater detail in Section IV.
3. The claims data are adjusted to update to the FY 2016 contract period; these trend adjustments are described in Section V. The resulting claims are shown in Exhibits 4a and 4b under the column "Completed & Trended Claims".
4. The data are further adjusted to reflect expected managed care savings, which is applied to the UPL PMPM and results in the PACE PMPM.
5. The managed care adjusted claims from Step 4 are divided by the count of member months for each rate cell (from Exhibits 1a and 1b) to arrive at preliminary PMPM costs by service category. These PMPM costs are

[1] Patient payment amounts are primarily for nursing home and personal care services.
[2] Patient payment amounts for adult day care, consumer directed, nursing home, and personal care services are carried forward to the capitation rate calculations in Exhibits 4a and 4b.

summarized for each dual eligibility status and region. Claims are summed to calculate health care cost components for PACE.

6. The final step is adding an allowance for PACE plan administrative costs. The rates shown in Exhibit 5a and 5c include only the Medicaid portion of the payment. The PACE program will also receive a capitation payment from the federal government for the Medicare component of services for dual eligibles.
7. The PACE rates are compared to the estimated Upper Payment Limit cost to confirm that FY 2016 PACE rates meet federal rate setting guidelines.

IV. Programmatic and legislative adjustments

Prescription drug adjustment

Under the guideline of actuarial soundness for managed care programs, States are not required to reduce the outpatient prescription drug payment by the amount of state drug rebates. However, the PACE rate-setting checklist requires that UPLs be developed based on the FFS equivalent cost. The prescription drug adjustment was based upon a combination of analysis of the DMAS FFS pharmacy payments, including rebate amounts, unit cost, utilization rates, dispensing fees, and application of co-payments.

For the Dual Demonstration population, the majority of prescriptions are covered under the Medicare Part D drug benefit. The Virginia Medicaid program continues to cover the prescription drugs for which federal matching funds remain available but which are specifically excluded by law from Medicare Part D and to cover specific DMAS approved over-the-counter (OTC) drugs, which are also excluded from Part D. For the Medicare Part B covered drugs, DMAS continues to pay for coinsurance and deductibles. Effective January 1, 2013, Medicare Part D began to cover benzodiazepines with no restrictions and barbiturates when used in the treatment of epilepsy, cancer or chronic mental disorders and are no longer paid by Virginia Medicaid. These drugs are removed from the base data for the dual population in Exhibit 1a, which primarily affects cost and utilization in the period July 1 to December 31, 2012. Prescription drug costs for the non-dual population are covered by the Medicaid program and there is no adjustment to those costs in Exhibit 1b.

The DMAS dispensing fee during the data period of FY 2013 and FY 2014 was $3.75 per script. Dispensing fees during the base period were reported as $3.75 or as $0.00 because no dispensing fee is paid if the same prescription is filled more than one time in a month. Therefore the data period dispensing fee average is less than $3.75. The resulting FY 2016 average dispensing fees are $3.20 for duals and $3.07 for the non-dual population.

DMAS Medicaid prescription co-payments on brand name drugs are set at $3.00 and the co-payment for generic drugs is $1.00. As mandated by Federal law, co-payments are not imposed on recipients in nursing homes or in community based waivers, although a small amount of co-payment were reported in the FFS data. Because PACE members are certified as nursing home eligible, we have not calculated or applied any further co-payment adjustment.

The DMAS discounts, rebates, and dispensing fees, are applied for the non-dual population, but different adjustments are applied for the dual eligible population. The prescription drugs covered by Medicaid for the dual eligible population contain a different mix of drugs than that used by the non-dual population; the dual mix includes a higher proportion of over-the-counter (OTC) and specialized drugs that do not receive the same discounts and rebates as other Medicaid covered drugs. This mix was considered in calculating the total FFS rebate percentage for the PACE-eligible dual population. Based on analysis of the more recent non-dual claims, we kept the same level of assumed savings from future expected improvements in the Brand-Generic mix.

These adjustments are calculated in Exhibit 2a and applied to the total historical claims data in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

Non-emergency transportation adjustment

Non-emergency transportation (NET) services were contracted to a broker during the historical data period under a capitated payment methodology and services are not captured in the DMAS FFS claims. The non-emergency transportation adjustment is based on the service cost component (including the administrative cost) of the accepted bid for the ABAD nursing home population, a statewide rate at $47.22 PMPM for FY 2016 effective October 2014. The per member per month value is shown in Exhibit 2b and the adjustment is applied in the total UPL column in Exhibits 4a and 4b.

Adult day care fee adjustment

This adjustment incorporates a fee increase of $10 per day effective July 1, 2013, the beginning of FY 2014. Northern Virginia rates are higher than the rest of the state; therefore the value of the increase is calculated separately. The calculation is shown in Exhibit 2c, and the adjustment is applied in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

Hospital inpatient adjustment

While there was no explicit unit cost increase for FY 2014, hospital reimbursement rates were rebased resulting in a weighted average cost per unit change of 4.7% for inpatient medical/surgical and -7.4% for inpatient psychiatric.

For both FY 2015 and FY 2016, the Virginia General Assembly did not provide a budget regulatory increase so there is no unit cost increase.

For inpatient medical/surgical, the positive adjustment is 2.1%. For inpatient psychiatric in acute care hospitals, the negative adjustment is 4.2%. The inpatient psychiatric factor is applied to mental health claims.

These adjustment factors are shown in Exhibit 2d and applied to all hospital inpatient service categories in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

Nursing facility adjustment

Nursing facility payment can include adjustments to the operating and/or the capital component of the rate. The operating component includes two sub-components; the direct operating rate and the indirect operating rate. The Virginia General Assembly authorized a 2.2% inflation increase for the operating component of the rates in FY 2013 and FY 2014 and an additional 1% increase in FY 2013, for a net increase of 1.1% in FY 2014. An additional increase of 3.2% was authorized for FY 2015.

DMAS estimates that 9.7% of the total nursing facility payment is for the capital rent. The Virginia General Assembly authorized a capital rental rate decrease of 3.2% for FY 2015. There is an additional change to the minimum occupancy requirements from 90% to 88% that affects the indirect operating rate and the capital rate components of nursing facility reimbursement.

DMAS provided information on supplemental payments to nursing facilities that are based upon DMAS reconciliation to nursing home submitted cost reports and which are not included in the historical claims databases. An adjustment for the supplemental payments is calculated against the total remitted claims. The 4.5% cost settlement percentage was provided by DMAS and is applied to the DMAS paid amount on the Nursing Facility service line. Nursing facility patient payments do not receive any of the adjustments.

The calculation is shown in Exhibit 2e, and the adjustment is applied in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

DME Fees adjustment

Effective FY 2015, the approved budget reduced Medicaid fees for the DME products covered under the Medicare competitive bid program to a level based on the average of the Medicare competitive bid prices in the three areas of the state participating in the competitive bid program. This was estimated to result in $4.9 million in total savings. DMAS estimated that the Medicare competitive bid rates for these services were 33% lower than the FFS Medicaid rates for the services. DMAS provided a list of DME HCPCS codes subject to the Medicare competitive bid program and the average Medicare bid payment rate for the three areas in Virginia that participate in the program. This information was used to determine the proportion of DME claims subject to the fee reduction and the average savings percentage based on the mix of DME codes subject to the savings. Overall, 6% of PACE eligible DME claims dollars were for codes subject to the reduction, and savings on this subset was 33.7%. When that savings is applied to the proportion of DME costs, the overall savings is 2.1%. The calculation is shown in Exhibit 2f, and the adjustment is applied in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

Incontinence Supplies adjustment

DMAS solicited bids for the cost of high volume incontinence supplies, primarily adult diapers and protection pads. When compared to current DMAS payment rates, the bid prices were estimated to produce nearly $2.7 million in savings, or 33% of the cost of the mix of those supplies. DMAS provided a list of DME incontinence supplies HCPCS codes subject to the bid program and the bid rate for the items. These were used to calculate the dollar cost savings per unit and a savings percentage per affected DME code. This information was applied to the historical claims to determine the proportion of DME claims subject to the incontinence supplies fee reduction and the average savings percentage based on the mix of DME codes subject to the savings. Overall, about 66.8% of duals and 9.4% of non-duals claims dollars were for incontinence supply codes subject to the reduction. Savings on this subset are 31.8% and 33.5%%, respectively for dual and non-dual eligibles.

This results in adjustment factor reduction that of 21.2% and 3.1% as shown in Exhibit 2g. The adjustment is added in Exhibits 4a to 4b under the column labeled "Policy and Program Adjustments."

Lab Fees adjustment

The FY 2015 final budget included a 12% reduction to lab fees ($2.1 million in FFS savings). The 12% reduction was chosen to match the payment rates already in place for the Medallion 3.0 plans. Therefore, this adjustment is applied to any rates based on FFS claims data, including the PACE eligible population. It is shown in Exhibit 2h and added in Exhibit 4a and 4c under the column labeled "Policy and Program Adjustments".

Hepatitis C treatment adjustment

The Hepatitis C Treatment adjustment uses the value calculated for the ALTC Adult population as described in the FY 2016 Medallion 3.0 report. The Dual population will receive Hepatitis C treatment and drug therapy through their Medicare primary coverage. Therefore, the Hepatitis C Treatment adjustment value is applied only to the non-Dual population rate development.

It is shown in Exhibit 2i and added in Exhibit 4a and 4c under the column labeled "Policy and Program Adjustments".

ER Triage adjustment

The 2015 General Assembly final Budget conference report eliminated ER triage for physician services. Current DMAS FFS policy applies ER Triage review only to Level III ER claims. If a case is determined to have insufficient documentation of medical necessity for an emergency, DMAS could reduce the physician payment to an all-inclusive rate of $22.06 for the code 99283 instead of paying the physician fee of $43.57 plus ancillaries. Eliminating the ER Triage review will increase the Level III ER payment to physicians by the difference in the 99283 physician fee plus the average amount of ancillary services billed on those claims.

The ER Triage adjustment reflects the additional amount estimated to cover the cost of discontinuing Level III Triage review and paying such claims at the average fee for CPT code 99283, plus the average of the ancillary payments that are associated with the claim. The historical base FFS data was analyzed in order to identify the number of Level III ER claims paid at the ER Triage level and was re-priced to reflect DMAS FFS average cost of a Level III professional claim paid in full at $43.57. For Level III claims for non-dual eligibles, this is approximately $11,000 based on the FY 2013 and FY 2014 number of claims.

The calculation of the additional cost is presented in Exhibit 2j. The adjustment is added in Exhibits 4a to 4b under the column labeled “Policy and Program Adjustments.”

RBRVS rebasing adjustment

Each year DMAS adjusts physician rates consistent with the Medicare RBRVS update in a budget neutral manner based on funding. Up until last year, the update was based solely on DMAS FFS data. Plans have reported that the rebasing is not cost neutral to their operations and that the impact on them varies. Last year the DMAS update used both FFS and MCO data. The FY 2016 DMAS analysis used both FFS and the MCO data, as repriced to the DMAS physician fee schedule. Claims covered all professional providers, including physicians, nurse practitioners, psychologists, therapists, opticians, and federally qualified health centers and the full range of CPT codes from 10000 to 99499. The new physician rates for FY16 result in a -0.2 percent reduction to the MCO experience and a 0.5% increase to the FFS experience. Other codes, such as J codes for drugs administered in an office setting and anesthesia-related codes that are grouped in the professional service categories, are excluded from the adjustment.

The managed care professional fee adjustment is approximately 0.5%. The calculation of the RBRVS adjustment is shown in Exhibit 2k. The adjustment is added in Exhibits 4a to 4b under the column labeled “Policy and Program Adjustments.”

Personal Care and Respite Care adjustment

The 2015 Virginia Appropriation Act increases personal care and respite care rates by 2% effective July 1, 2015. Under the contract, the plans are required to pay at least the Medicaid personal care and respite care rates. As a result, this FY 2016 effective fee change applies to relevant claims in the following three service categories: consumer directed services, personal care services, and outpatient mental health physician claims. The calculation of the Personal Care and Respite Care adjustment is shown in Exhibit 2l. The adjustment is added in Exhibits 4a to 4b under the column labeled "Policy and Program Adjustments."

Other adjustments

Managed Care Utilization Adjustment

A further adjustment is made to recognize utilization efficiencies under managed care relative to the FFS system.

Because of the limited number of PACE programs, the voluntary nature of the programs and the small enrollment in each program, there are few estimates of managed care savings based upon actual utilization. Those that are available report net Medicaid savings on the order of 15 percent or more. We also reviewed administrative financial data provided by the contracting PACE plans and conducted discussions with DMAS staff.

The actual level of managed care savings that can be realized depends upon a number of factors. Consequently, there is a range of reasonable savings assumptions. We have assumed that PACE plan utilization management and cost controls will result in reductions in overall costs of 18.4%. Prescription drugs and non-emergency transportation are exempt from the adjustment[3]. A small brand-generic improvement factor for prescription drugs for the non-dual population is incorporated as a managed care savings in the Prescription Drug Adjustment described earlier and the non-emergency transportation adjustment is added as the contracted FY 2016 value.

The managed care adjustment factor is shown in Exhibit 2m and is applied in Exhibits 4a and 4b under the column labeled "Managed Care Utilization Adjustment". The managed care adjustment must be considered in conjunction with the administrative cost adjustment described below, to arrive at the expectation of net Medicaid savings.

Administrative Cost Adjustment

The CMS regulations require that administrative costs directly related to the provision of Medicaid State Plan approved services be incorporated into the rate-setting process. The PACE plans provided revenue and administrative cost data for FY 2013 and/or FY 2014 as downloads from their financial reporting systems. These were evaluated to assist in determining an appropriate administrative factor.

The data submitted by the plans included overhead and allocation charges from the integrated delivery system operations that can be classified as medical costs. Because a number of the PACE programs are relatively new and have small enrollment, there was wide variation in reported administrative cost. The administrative cost percentage is expected to decline as full operations are established and enrollment grows. A 15% administrative cost factor is applied to the total adjusted and trended claims amount for each rate payment category. This adjustment is shown in Exhibit 2m. This adjustment factor is applied in the final step of the per capita cost calculations at the bottom of each rate cell worksheet in Exhibits 4a and 4b.

[3] The small amount of non-dual Medicare crossover services is also exempt from the managed care utilization adjustment.

V. Trend adjustments

The data used for the IBNR and trend calculations reflect experience for the period FY 2012 through FY 2014. Data for FY 2013 to FY 2014 is used to evaluate the base period trend and an additional year of data, FY 2012 through FY 2014, is used to develop contract period projected trend.

The data must be adjusted to reflect the contract period of FY 2016 through the application of trend rates that reflect changes in payment levels and utilization rates between the data period and the contract period. In addition, the claims data are not 100% "complete" in that some cost information is not available in the claims databases provided. Incomplete data result from the time lag between when services are provided and claims are fully paid. The amount of incomplete claims is referred to as Incurred but Not Reported (IBNR) and can be measured through actuarial models.

Trend and IBNR adjustment factors were developed using historical Virginia Medicaid FFS expenditures for FY 2012 to FY 2014 and are calculated separately for the dual and the non-dual populations. We also had paid claims information with run out through February 2015 and took into consideration the actual experience and information from DMAS on projected utilization and fee increases in budget estimates.

The historical data were evaluated using a PwC model that estimates IBNR amounts using a variety of actuarially accepted methods, and trend using a least-squares regression methodology. Trend and IBNR factors were developed separately for the following service categories: Inpatient Medical/Surgical, Inpatient Psych, Outpatient Hospital, Practitioner, Prescription Drug, Personal Care, Consumer Directed Services, and Other. The Other category includes Lab/X-Ray services, DME and transportation. IBNR factors and trend rates for the Medicare crossover service categories for the dual population, which are combined across all services, and long term care services, including Nursing Facility, Adult Day Care, and Personal Care were developed from analysis of the historical data.

Annual trend rates are applied to move the historical data from the midpoint of the data period (7/1/2013) to the 1/1/2015, or two and a half years (30 months). Each category of service in Exhibits 3a and 3b shows a Data Period and a Contract Period trend. Data Period trends are applied from the midpoint of the data period to the end of the data period, and were developed from the historical regression analyses and budget work described above. The Contract Period trends are applied from the end of the data period to the midpoint of the contract period. For services with fee increases reflected in the adjustments in 2a through 2l, the contract period trend is in conjunction with the planned cost per unit increase.

Trend rates represent a combination of cost and utilization increases over time. The trend rates used reflect utilization and standard rate increases when additional legislative cost increases or decreases have been applied and represent PMPM increases otherwise. Specifically, the trend models are adjusted for the fee increases or decreases that occurred during the historical base period that are presented as adjustments in Exhibits 2a to 2l. In addition, the Dual data period pharmacy trend was adjusted to remove drugs that are now covered under Medicare Part D. Effective January 1, 2013, Medicare Part D began to cover benzodiazepines with no restrictions and barbiturates when used in the treatment of epilepsy, cancer or chronic mental disorders and therefore they are no longer paid by Virginia Medicaid. As necessary, adjustments are also made to in the contract trend models to reflect any fee changes in FY 2012, the year prior to the base data, which is used to develop the contract period trend.

A number greater than 1.0 reflects an increase to the underlying data while a number less than 1.0 represents a decrease. Adjustments to the historical data before the analysis of trend were applied to both the dual and the non-dual trend and are presented in the following table.

Table 1
Summary of Adjustments to Trend

Service	Time Period	PACE Adjustment
Nursing Facility	Jul 2012 – Jun 2013	0.969
	Jul 2013 – Jun 2014	0.959
	Jul 2014 – Feb 2015	0.935
Personal Care with Consumer Directed PC	Jul 2012 – Feb 2015	0.990
Inpatient – Med/Surg	Jul 2012 – Jun 2013	0.977
	Jul 2013 – Feb 2015	0.959
Inpatient – Psych	Jul 2012 – Jun 2013	0.977
	Jul 2013 – Feb 2015	1.073
Adult Day Care	Jul 2013 – Feb 2015	0.834
Other	Jul 2012 - Jun 2014	Dual 0.951 Non-Dual 1.000
	Jul 2014 – Feb 2015	Dual 0.975 Non-Dual 1.052

The evaluation of nursing home (including Medicare crossover), adult day care, consumer directed services, and personal care services trend included both DMAS and patient payment amounts. Adult Day Health, Consumer Direction, and personal care were each evaluated as an independent service. The total trend rates shown in Exhibits 3a and 3b represent the combination of Data Period and Contract Period trends, and are calculated using compound interest calculations. For these rates, a number of the dual and non-dual data period trend are negative. Contract period service category trend that is negative in the models is set to 0.0%. The result is that overall Medicaid data period trend is negative or flat and the contract period trend is slightly positive for both dual and non-dual. These trend/IBNR factors are applied to the historical data in Exhibits 4a and 4b by applicable service category in Exhibits 4a and 4b.

VI. Summary capitation rates

The historical data presented in Exhibits 1a and 1b is adjusted by the factors shown in Exhibits 2a through 2l and the Trend and IBNR factors in Exhibits 3a and 3b. These are applied in Exhibits 4a and 4b to determine the rates. This exhibit also presents the UPL rate summary.

A column is added to Exhibits 4a and 4b to show the comparative Upper Payment Limit (UPL) calculation. For most of the service lines, the value of the UPL PMPM is equal to the base period Medicaid payment, the completion factor adjustment, applicable policy and program adjustments, and trend. UPL is before the application of the managed care adjustment. For prescription drug and non-emergency transportation, the projected PMPM value is the same in the UPL and the FY 2016 PACE rates. The 2% administrative factor is the estimated cost of DMAS staff and monitoring activities for the existing FFS programs. The managed care adjustment and health plan administrative factor are applied to the UPL values to produce the PACE rates shown

in Exhibit 5a. Averages are weighted by the distribution of member months for the historical FY 2013 to FY 2014 time period. Overall, the PACE rates are approximately 5.6% below the Upper Payment Limit and therefore meet CMS PACE rate setting checklist requirements. Weighting by PACE enrollees as of February 2015 results in a slightly higher statewide total PMPM but PACE rates are below the Upper Payment Limit.

Analysis of the PACE eligible population by region indicates variation in the relative proportion of the eligible population that is in nursing homes and the proportion that is supported by home and community based services. The statewide proportion of the PACE eligible population in nursing homes has been decreasing over time. It was 62.1% of Dual and 46.7% of Non-Dual in the FY 2010 to FY 2011 base period used for the FY 2013 PACE rates. It dropped further for the FY 2011 to FY 2012 base period used in the FY 2014 PACE rate setting; 59.0% of the dual eligible population and 45.8% of the non-dual population was in nursing homes. For the FY 2013 to FY 2014 base period used in this year's rate development, 54.5% of the dual eligible population and 40.0% of the non-dual population was in nursing homes. These proportions, as reflected in member month counts for the historical data period, are shown in Table 2.

Table 2
Nursing Home vs. Non-Nursing Home Blending Factor

	Dual Population			Non-Dual Population		
	Member Months			Member Months		
Region	**NH**	**Non-NH**	**%NH**	**NH**	**Non-NH**	**%NH**
Northern Virginia	53,738	61,745	46.5%	4,701	6,983	40.2%
Other MSA	87,042	49,346	63.8%	4,154	5,431	43.3%
Richmond/Charlottesville	75,095	63,025	54.4%	4,920	8,908	35.6%
Rural	110,758	98,950	52.8%	5,778	10,025	36.6%
Tidewater	73,706	61,692	54.4%	7,329	9,038	44.8%
Statewide-PACE	400,338	334,758	**54.5%**	26,883	40,385	**40.0%**

PACE rates are benchmarked to the statewide average proportion of the eligible population that is in nursing homes. Therefore, the rates in Exhibit 5a are re-weighted to reflect a dual population that is 54.5% in nursing homes and a non-dual population with 40.0% in nursing homes. This is used in conjunction with cost factors that are the ratio of the average PMPM for those in nursing homes and those in community based care relative to the regional average PMPM. The relative cost factors and the resulting blending factors are presented in Exhibit 5b.

A comparison of the rates before and after the blending is shown in Exhibit 5c. PACE capitation rates for FY 2016 after the re-weighting are presented in Exhibit 5d. All averages are weighted by the distribution of member months for the historical FY 2013 to FY 2014 time period.

A comparison of FY 2016 PACE rates to FY 2015 rates in Exhibit 5e shows a 1.22% increase in the dual PACE rates and a -2.42% decrease in the non-dual PACE rates, resulting in an overall increase of 0.77%. The composite year-to-year change by region ranges from a 1.3% increase to a -0.1% decrease. When the regional rates are weighted by the February 2015 PACE enrollee population, there is a 1.19% increase in the dual population rates, a -2.56% decrease in the non-dual PACE rates, and an overall weighted year to year increase of 0.77%.

Actuarially sound rates should fall within a range of several percentage points, taking into consideration the technical calculations performed, PACE plan projected revenue requirements, known changes in provider

contracting arrangements, and other factors. Final rates for each plan are negotiated between DMAS and the PACE plan representatives.

VIRGINIA MEDICAID

Exhibit 1a

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Northern Virginia	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	115,483						
Service Type							
Adult Day Care	$6,343,331	$41,918	$6,385,249	$55.29	293,161	30,463	$21.78
Ambulatory Surgery Center	$1,817	$0	$1,817	$0.02	2	0	$908.46
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$27,269,897	$194,647	$27,464,545	$237.82	2,159,362	224,382	$12.72
DME/Supplies	$3,151,630	$640	$3,152,270	$27.30	35,714	3,711	$88.26
Emergency	$6,117	$0	$6,117	$0.05	11	1	$556.10
FQHC	$71	$0	$71	$0.00	1	0	$70.61
Home Health Services	$28,099	$0	$28,099	$0.24	102	11	$275.48
Inpatient - Medical/Surgical	$8,168,071	$125,598	$8,293,668	$71.82	1,122	117	$7,391.86
Inpatient - Psych	$350,434	$16,961	$367,395	$3.18	658	68	$558.35
Lab and X-ray Services	$13,574	$0	$13,574	$0.12	1,174	122	$11.56
Medicare Xover - IP	$2,515,260	$0	$2,515,260	$21.78	2,257	235	$1,114.43
Medicare Xover - Nursing Facility	$1,664,990	$25,322	$1,690,313	$14.64	100,558	10,449	$16.81
Medicare Xover - OP	$1,455,783	$192	$1,455,975	$12.61	12,478	1,297	$116.68
Medicare Xover - Other	$801,204	$48	$801,253	$6.94	40,322	4,190	$19.87
Medicare Xover - Physician	$3,580,023	$203	$3,580,226	$31.00	105,731	10,987	$33.86
Nursing Facility	$227,799,083	$50,717,127	$278,516,210	$2,411.75	1,438,197	149,445	$193.66
Outpatient - Other	$827,624	$0	$827,624	$7.17	265	28	$3,123.11
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$120,205,562	$445,533	$120,651,095	$1,044.75	1,139,645	118,422	$105.87
Physician - Clinic	$16,886	$0	$16,886	$0.15	4,659	484	$3.62
Physician - IP Mental Health	$6,276	$0	$6,276	$0.05	337	35	$18.62
Physician - OP Mental Health	$19,095,340	$15,764	$19,111,104	$165.49	1,218,200	126,585	$15.69
Physician - Other Practitioner	$761,262	$7	$761,269	$6.59	9,702	1,008	$78.47
Physician - PCP	$74,376	$2,009	$76,384	$0.66	1,466	152	$52.10
Physician - Specialist	$43,349	$1,924	$45,273	$0.39	1,415	147	$32.00
Pharmacy	$1,009,988	$0	$1,009,988	$8.75	156,157	16,226	$6.47
Transportation - Emergency	$5,555	$0	$5,555	$0.05	68	7	$81.69
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$425,195,601	$51,587,893	$476,783,493	$4,128.60	6,722,764		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID

Exhibit 1a

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Other MSA	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	136,388						
Service Type							
Adult Day Care	$552,252	$17,966	$570,218	$4.18	11,382	1,001	$50.10
Ambulatory Surgery Center	$1,545	$0	$1,545	$0.01	2	0	$772.33
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$30,392,902	$263,393	$30,656,295	$224.77	3,105,323	273,221	$9.87
DME/Supplies	$2,191,431	$327	$2,191,757	$16.07	34,505	3,036	$63.52
Emergency	$5,036	$0	$5,036	$0.04	16	1	$314.73
FQHC	$2,425	$656	$3,080	$0.02	49	4	$62.87
Home Health Services	$7,436	$0	$7,436	$0.05	60	5	$123.93
Inpatient - Medical/Surgical	$2,284,077	$153,781	$2,437,858	$17.87	743	65	$3,281.10
Inpatient - Psych	$14,259	$10	$14,269	$0.10	33	3	$432.39
Lab and X-ray Services	$17,678	$0	$17,678	$0.13	1,388	122	$12.74
Medicare Xover - IP	$3,445,425	$0	$3,445,425	$25.26	3,275	288	$1,052.04
Medicare Xover - Nursing Facility	$2,068,876	$65,380	$2,134,256	$15.65	147,489	12,977	$14.47
Medicare Xover - OP	$1,362,294	$0	$1,362,294	$9.99	12,989	1,143	$104.88
Medicare Xover - Other	$1,232,868	$64	$1,232,931	$9.04	66,287	5,832	$18.60
Medicare Xover - Physician	$3,817,755	$170	$3,817,925	$27.99	176,884	15,563	$21.58
Nursing Facility	$298,721,225	$72,293,847	$371,015,072	$2,720.30	2,327,167	204,755	$159.43
Outpatient - Other	$83,485	$181	$83,666	$0.61	424	37	$197.33
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$35,029,116	$408,346	$35,437,462	$259.83	576,631	50,735	$61.46
Physician - Clinic	$6,673	$0	$6,673	$0.05	3,876	341	$1.72
Physician - IP Mental Health	$463	$0	$463	$0.00	23	2	$20.12
Physician - OP Mental Health	$8,622,654	$3,863	$8,626,517	$63.25	496,096	43,649	$17.39
Physician - Other Practitioner	$1,216,690	$381	$1,217,071	$8.92	18,729	1,648	$64.98
Physician - PCP	$38,349	$1,549	$39,898	$0.29	1,221	107	$32.68
Physician - Specialist	$33,915	$1,773	$35,688	$0.26	1,248	110	$28.60
Pharmacy	$1,422,708	$0	$1,422,708	$10.43	226,384	19,918	$6.28
Transportation - Emergency	$9,742	$0	$9,742	$0.07	92	8	$105.89
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$392,581,275	$73,211,688	$465,792,963	$3,415.22	7,212,316		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID

Exhibit 1a

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	138,119						
Service Type							
Adult Day Care	$3,202,917	$76,135	$3,279,052	$23.74	66,906	5,813	$49.01
Ambulatory Surgery Center	$1,299	$0	$1,299	$0.01	4	0	$324.86
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$40,806,304	$443,677	$41,249,981	$298.66	4,172,683	362,529	$9.89
DME/Supplies	$3,951,637	$1,383	$3,953,019	$28.62	47,635	4,139	$82.99
Emergency	$11,095	$0	$11,095	$0.08	25	2	$443.79
FQHC	$655	$0	$655	$0.00	8	1	$81.90
Home Health Services	$14,458	$0	$14,458	$0.10	62	5	$233.19
Inpatient - Medical/Surgical	$2,170,378	$166,524	$2,336,902	$16.92	750	65	$3,115.87
Inpatient - Psych	$0	$0	$0	$0.00	0	0	$0.00
Lab and X-ray Services	$13,576	$0	$13,576	$0.10	962	84	$14.11
Medicare Xover - IP	$4,115,582	$0	$4,115,582	$29.80	4,006	348	$1,027.35
Medicare Xover - Nursing Facility	$2,060,071	$41,127	$2,101,198	$15.21	142,270	12,361	$14.77
Medicare Xover - OP	$1,542,607	$0	$1,542,607	$11.17	17,364	1,509	$88.84
Medicare Xover - Other	$1,227,669	$177	$1,227,846	$8.89	67,464	5,861	$18.20
Medicare Xover - Physician	$4,606,415	$237	$4,606,652	$33.35	176,314	15,318	$26.13
Nursing Facility	$261,185,854	$69,346,357	$330,532,211	$2,393.10	2,012,711	174,868	$164.22
Outpatient - Other	$154,139	$0	$154,139	$1.12	233	20	$661.54
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$56,094,149	$677,273	$56,771,422	$411.03	825,974	71,762	$68.73
Physician - Clinic	$766	$0	$766	$0.01	348	30	$2.20
Physician - IP Mental Health	$1,879	$0	$1,879	$0.01	76	7	$24.72
Physician - OP Mental Health	$10,893,316	$5,934	$10,899,250	$78.91	724,223	62,922	$15.05
Physician - Other Practitioner	$1,539,989	$569	$1,540,559	$11.15	24,913	2,164	$61.84
Physician - PCP	$62,540	$653	$63,193	$0.46	1,348	117	$46.88
Physician - Specialist	$43,624	$2,563	$46,187	$0.33	1,484	129	$31.12
Pharmacy	$1,209,515	$0	$1,209,515	$8.76	182,026	15,815	$6.64
Transportation - Emergency	$5,591	$0	$5,591	$0.04	66	6	$84.71
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$394,916,023	$70,762,610	$465,678,633	$3,371.57	8,469,855		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID

Exhibit 1a

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Rural	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	209,709						
Service Type							
Adult Day Care	$562,145	$1,975	$564,120	$2.69	11,272	645	$50.05
Ambulatory Surgery Center	$3,623	$1,341	$4,964	$0.02	5	0	$992.79
Case Management Services	$18,698	$0	$18,698	$0.09	5,615	321	$3.33
Consumer Directed Services	$62,847,246	$423,830	$63,271,075	$301.71	6,427,243	367,781	$9.84
DME/Supplies	$4,532,144	$2,981	$4,535,125	$21.63	70,571	4,038	$64.26
Emergency	$15,574	$0	$15,574	$0.07	53	3	$293.85
FQHC	$9,897	$251	$10,148	$0.05	151	9	$67.21
Home Health Services	$22,088	$0	$22,088	$0.11	101	6	$218.69
Inpatient - Medical/Surgical	$2,642,895	$135,814	$2,778,709	$13.25	963	55	$2,885.47
Inpatient - Psych	$0	$0	$0	$0.00	0	0	$0.00
Lab and X-ray Services	$29,911	$0	$29,911	$0.14	2,425	139	$12.33
Medicare Xover - IP	$5,862,102	$3,524	$5,865,626	$27.97	5,533	317	$1,060.12
Medicare Xover - Nursing Facility	$3,471,049	$72,340	$3,543,389	$16.90	238,073	13,623	$14.88
Medicare Xover - OP	$3,087,079	$523	$3,087,602	$14.72	31,026	1,775	$99.52
Medicare Xover - Other	$2,239,431	$317	$2,239,748	$10.68	122,463	7,008	$18.29
Medicare Xover - Physician	$6,076,587	$1,280	$6,077,868	$28.98	280,793	16,068	$21.65
Nursing Facility	$349,446,941	$81,977,092	$431,424,032	$2,057.25	2,907,261	166,360	$148.40
Outpatient - Other	$104,240	$0	$104,240	$0.50	678	39	$153.75
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$72,841,097	$968,176	$73,809,274	$351.96	1,272,431	72,811	$58.01
Physician - Clinic	$37,164	$0	$37,164	$0.18	4,635	265	$8.02
Physician - IP Mental Health	$276	$0	$276	$0.00	17	1	$16.25
Physician - OP Mental Health	$15,130,241	$1,492	$15,131,733	$72.16	988,072	56,540	$15.31
Physician - Other Practitioner	$2,486,022	$1,912	$2,487,934	$11.86	40,653	2,326	$61.20
Physician - PCP	$111,971	$2,517	$114,488	$0.55	4,322	247	$26.49
Physician - Specialist	$66,309	$3,857	$70,166	$0.33	2,318	133	$30.27
Pharmacy	$1,985,760	$0	$1,985,760	$9.47	298,921	17,105	$6.64
Transportation - Emergency	$24,219	$0	$24,219	$0.12	141	8	$171.77
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$533,654,710	$83,599,222	$617,253,933	$2,943.39	12,715,736		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID

Exhibit 1a

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Tidewater	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	135,398						
Service Type							
Adult Day Care	$347,242	$1,176	$348,418	$2.57	6,912	613	$50.41
Ambulatory Surgery Center	$9,150	$7,459	$16,609	$0.12	24	2	$692.04
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$14,017,396	$136,280	$14,153,676	$104.53	1,429,601	126,702	$9.90
DME/Supplies	$3,807,533	$1,289	$3,808,821	$28.13	46,667	4,136	$81.62
Emergency	$5,047	$0	$5,047	$0.04	17	2	$296.90
FQHC	$453	$665	$1,118	$0.01	13	1	$85.97
Home Health Services	$17,661	$0	$17,661	$0.13	70	6	$252.29
Inpatient - Medical/Surgical	$2,182,280	$138,199	$2,320,479	$17.14	623	55	$3,724.69
Inpatient - Psych	$8,580	$0	$8,580	$0.06	15	1	$572.00
Lab and X-ray Services	$12,861	$0	$12,861	$0.09	977	87	$13.16
Medicare Xover - IP	$3,446,548	$1,114	$3,447,662	$25.46	3,131	277	$1,101.14
Medicare Xover - Nursing Facility	$1,450,486	$55,402	$1,505,887	$11.12	99,932	8,857	$15.07
Medicare Xover - OP	$1,583,640	$129	$1,583,769	$11.70	17,633	1,563	$89.82
Medicare Xover - Other	$1,216,276	$69	$1,216,345	$8.98	64,145	5,685	$18.96
Medicare Xover - Physician	$4,970,851	$295	$4,971,146	$36.72	217,126	19,243	$22.90
Nursing Facility	$242,357,698	$71,041,659	$313,399,357	$2,314.65	1,991,581	176,509	$157.36
Outpatient - Other	$49,718	$0	$49,718	$0.37	115	10	$432.33
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$92,952,852	$929,569	$93,882,421	$693.38	1,277,721	113,241	$73.48
Physician - Clinic	$28	$0	$28	$0.00	2	0	$13.88
Physician - IP Mental Health	$0	$0	$0	$0.00	0	0	$0.00
Physician - OP Mental Health	$19,258,391	$8,127	$19,266,518	$142.30	1,412,396	125,177	$13.64
Physician - Other Practitioner	$740,894	$392	$741,286	$5.47	30,767	2,727	$24.09
Physician - PCP	$44,238	$2,501	$46,739	$0.35	1,207	107	$38.72
Physician - Specialist	$51,871	$1,196	$53,068	$0.39	1,603	142	$33.11
Pharmacy	$1,208,656	$0	$1,208,656	$8.93	179,881	15,942	$6.72
Transportation - Emergency	$3,804	$0	$3,804	$0.03	46	4	$82.70
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$389,744,154	$72,325,520	$462,069,674	$3,412.67	6,782,205		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
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VIRGINIA MEDICAID

Exhibit 1a

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
All Regions	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	735,097						
Service Type							
Adult Day Care	$11,007,886	$139,171	$11,147,057	$15.16	389,633	6,361	$28.61
Ambulatory Surgery Center	$17,434	$8,800	$26,234	$0.04	37	1	$709.03
Case Management Services	$18,698	$0	$18,698	$0.03	5,615	92	$3.33
Consumer Directed Services	$175,333,745	$1,461,827	$176,795,572	$240.51	17,294,211	282,317	$10.22
DME/Supplies	$17,634,373	$6,620	$17,640,993	$24.00	235,092	3,838	$75.04
Emergency	$42,869	$0	$42,869	$0.06	122	2	$351.38
FQHC	$13,501	$1,571	$15,072	$0.02	222	4	$67.89
Home Health Services	$89,741	$0	$89,741	$0.12	395	6	$227.19
Inpatient - Medical/Surgical	$17,447,701	$719,915	$18,167,616	$24.71	4,201	69	$4,324.59
Inpatient - Psych	$373,273	$16,971	$390,244	$0.53	706	12	$552.75
Lab and X-ray Services	$87,600	$0	$87,600	$0.12	6,926	113	$12.65
Medicare Xover - IP	$19,384,918	$4,638	$19,389,556	$26.38	18,202	297	$1,065.24
Medicare Xover - Nursing Facility	$10,715,471	$259,572	$10,975,043	$14.93	728,322	11,889	$15.07
Medicare Xover - OP	$9,031,403	$844	$9,032,247	$12.29	91,490	1,494	$98.72
Medicare Xover - Other	$6,717,448	$676	$6,718,123	$9.14	360,681	5,888	$18.63
Medicare Xover - Physician	$23,051,631	$2,186	$23,053,817	$31.36	956,848	15,620	$24.09
Nursing Facility	$1,379,510,800	$345,376,081	$1,724,886,882	$2,346.48	10,676,917	174,294	$161.55
Outpatient - Other	$1,219,205	$181	$1,219,386	$1.66	1,715	28	$711.01
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$377,122,776	$3,428,898	$380,551,674	$517.69	5,092,402	83,130	$74.73
Physician - Clinic	$61,517	$0	$61,517	$0.08	13,520	221	$4.55
Physician - IP Mental Health	$8,894	$0	$8,894	$0.01	453	7	$19.63
Physician - OP Mental Health	$72,999,942	$35,179	$73,035,121	$99.35	4,838,987	78,993	$15.09
Physician - Other Practitioner	$6,744,857	$3,261	$6,748,118	$9.18	124,764	2,037	$54.09
Physician - PCP	$331,473	$9,228	$340,701	$0.46	9,564	156	$35.62
Physician - Specialist	$239,069	$11,313	$250,382	$0.34	8,068	132	$31.03
Pharmacy	$6,836,627	$0	$6,836,627	$9.30	1,043,369	17,032	$6.55
Transportation - Emergency	$48,911	$0	$48,911	$0.07	413	7	$118.43
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$2,136,091,763	$351,486,932	$2,487,578,696	$3,384.02	41,902,875		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID

Exhibit 1b

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Northern Virginia	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	11,684						
Service Type							
Adult Day Care	$106,477	$0	$106,477	$9.11	3,797	3,900	$28.04
Ambulatory Surgery Center	$9,230	$0	$9,230	$0.79	13	13	$709.96
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$4,227,417	($638)	$4,226,779	$361.74	334,721	343,760	$12.63
DME/Supplies	$867,924	$101	$868,026	$74.29	8,160	8,380	$106.38
Emergency	$650,250	$0	$650,250	$55.65	995	1,022	$653.52
FQHC	$11,220	$0	$11,220	$0.96	135	139	$83.11
Home Health Services	$455,557	$0	$455,557	$38.99	1,463	1,503	$311.39
Inpatient - Medical/Surgical	$10,728,478	$720	$10,729,198	$918.24	891	915	$12,041.75
Inpatient - Psych	$4,129	$0	$4,129	$0.35	6	6	$688.19
Lab and X-ray Services	$400,689	$0	$400,689	$34.29	22,131	22,729	$18.11
Medicare Xover - IP	$1,184	$0	$1,184	$0.10	1	1	$1,184.00
Medicare Xover - Nursing Facility	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - OP	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Other	$456	$0	$456	$0.04	18	18	$25.33
Medicare Xover - Physician	$6	$0	$6	$0.00	2	2	$2.85
Nursing Facility	$24,157,612	$1,354,977	$25,512,589	$2,183.46	137,393	141,103	$185.69
Outpatient - Other	$2,658,083	$0	$2,658,083	$227.49	3,293	3,382	$807.19
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$11,824,059	$7,975	$11,832,035	$1,012.63	110,043	113,015	$107.52
Physician - Clinic	$1,139,830	$0	$1,139,830	$97.55	196,145	201,442	$5.81
Physician - IP Mental Health	$1,651	$0	$1,651	$0.14	21	22	$78.61
Physician - OP Mental Health	$2,371,895	$0	$2,371,895	$203.00	143,020	146,882	$16.58
Physician - Other Practitioner	$814,093	$7	$814,100	$69.67	9,413	9,667	$86.49
Physician - PCP	$1,290,693	$27	$1,290,720	$110.46	23,169	23,795	$55.71
Physician - Specialist	$984,874	$111	$984,985	$84.30	21,621	22,205	$45.56
Pharmacy	$6,627,803	$0	$6,627,803	$567.23	106,442	109,316	$62.27
Transportation - Emergency	$222,240	$0	$222,240	$19.02	2,679	2,751	$82.96
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$69,555,850	$1,363,280	$70,919,130	$6,069.52	1,125,572		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.
Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID

Exhibit 1b

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Other MSA	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	9,585						
Service Type							
Adult Day Care	$80,798	$0	$80,798	$8.43	1,573	1,969	$51.37
Ambulatory Surgery Center	$16,618	$0	$16,618	$1.73	25	31	$664.71
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$3,689,017	$1,662	$3,690,679	$385.06	375,710	470,385	$9.82
DME/Supplies	$1,046,649	$763	$1,047,412	$109.28	10,205	12,777	$102.64
Emergency	$449,476	$0	$449,476	$46.90	1,043	1,306	$430.95
FQHC	$50,230	$0	$50,230	$5.24	814	1,019	$61.71
Home Health Services	$403,877	$0	$403,877	$42.14	1,308	1,638	$308.77
Inpatient - Medical/Surgical	$9,491,747	$0	$9,491,747	$990.30	1,084	1,357	$8,756.22
Inpatient - Psych	$53,073	$0	$53,073	$5.54	78	98	$680.42
Lab and X-ray Services	$357,586	$0	$357,586	$37.31	21,219	26,566	$16.85
Medicare Xover - IP	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Nursing Facility	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - OP	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Other	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Physician	$4	$0	$4	$0.00	3	4	$1.31
Nursing Facility	$18,193,257	$706,450	$18,899,707	$1,971.85	121,390	151,979	$155.69
Outpatient - Other	$2,012,652	$0	$2,012,652	$209.99	3,522	4,410	$571.45
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$2,936,067	$3,831	$2,939,897	$306.73	48,921	61,249	$60.09
Physician - Clinic	$588,385	$0	$588,385	$61.39	81,897	102,534	$7.18
Physician - IP Mental Health	$1,588	$0	$1,588	$0.17	20	25	$79.39
Physician - OP Mental Health	$1,321,823	$4	$1,321,827	$137.91	50,120	62,750	$26.37
Physician - Other Practitioner	$656,461	$22	$656,483	$68.49	10,122	12,673	$64.86
Physician - PCP	$999,260	$24	$999,284	$104.26	34,619	43,343	$28.87
Physician - Specialist	$816,080	$18	$816,098	$85.15	16,545	20,714	$49.33
Pharmacy	$5,959,495	$0	$5,959,495	$621.77	108,351	135,654	$55.00
Transportation - Emergency	$369,813	$0	$369,813	$38.58	5,906	7,394	$62.62
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$49,493,956	$712,773	$50,206,729	$5,238.19	894,475		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.
Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID

Exhibit 1b

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	13,829						
Service Type							
Adult Day Care	$496,159	$0	$496,159	$35.88	17,042	14,788	$29.11
Ambulatory Surgery Center	$12,258	$0	$12,258	$0.89	22	19	$557.18
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$7,116,813	$6,649	$7,123,462	$515.13	728,438	632,115	$9.78
DME/Supplies	$1,455,789	$90	$1,455,879	$105.28	12,917	11,209	$112.71
Emergency	$931,284	$0	$931,284	$67.34	1,622	1,408	$574.16
FQHC	$74,635	$0	$74,635	$5.40	1,105	959	$67.54
Home Health Services	$524,484	$0	$524,484	$37.93	1,910	1,657	$274.60
Inpatient - Medical/Surgical	$12,672,788	$840	$12,673,627	$916.48	1,039	902	$12,197.91
Inpatient - Psych	$116,951	$0	$116,951	$8.46	174	151	$672.13
Lab and X-ray Services	$437,835	$0	$437,835	$31.66	24,006	20,832	$18.24
Medicare Xover - IP	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Nursing Facility	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - OP	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Other	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Physician	$0	$0	$0	$0.00	0	0	$0.00
Nursing Facility	$21,694,103	$935,689	$22,629,793	$1,636.45	143,092	124,171	$158.15
Outpatient - Other	$3,292,494	$0	$3,292,494	$238.09	5,557	4,822	$592.49
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$5,508,313	$5,160	$5,513,473	$398.70	86,458	75,025	$63.77
Physician - Clinic	$1,366,574	$0	$1,366,574	$98.82	207,809	180,330	$6.58
Physician - IP Mental Health	$3,282	$0	$3,282	$0.24	64	56	$51.28
Physician - OP Mental Health	$2,241,999	$455	$2,242,454	$162.16	86,369	74,948	$25.96
Physician - Other Practitioner	$1,138,021	$5	$1,138,026	$82.30	13,500	11,715	$84.30
Physician - PCP	$1,082,545	$76	$1,082,622	$78.29	24,052	20,872	$45.01
Physician - Specialist	$1,025,632	$132	$1,025,764	$74.18	22,803	19,788	$44.98
Pharmacy	$6,806,437	$0	$6,806,437	$492.20	124,104	107,693	$54.84
Transportation - Emergency	$351,100	$0	$351,100	$25.39	5,962	5,174	$58.89
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$68,349,496	$949,096	$69,298,592	$5,011.26	1,508,045		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.
Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID

Exhibit 1b

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Rural	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	15,803						
Service Type							
Adult Day Care	$7,624	$0	$7,624	$0.48	137	104	$55.65
Ambulatory Surgery Center	$20,524	$0	$20,524	$1.30	37	28	$554.71
Case Management Services	$1,855	$0	$1,855	$0.12	557	423	$3.33
Consumer Directed Services	$7,187,284	$10,892	$7,198,176	$455.49	735,186	558,255	$9.79
DME/Supplies	$1,758,991	$246	$1,759,238	$111.32	18,324	13,914	$96.01
Emergency	$939,454	$0	$939,454	$59.45	2,291	1,740	$410.06
FQHC	$234,076	$5	$234,081	$14.81	3,275	2,487	$71.48
Home Health Services	$950,438	$0	$950,438	$60.14	3,195	2,426	$297.48
Inpatient - Medical/Surgical	$14,119,934	$1,656	$14,121,590	$893.59	2,328	1,768	$6,065.98
Inpatient - Psych	$16,882	$0	$16,882	$1.07	26	20	$649.32
Lab and X-ray Services	$560,146	$0	$560,146	$35.45	35,001	26,578	$16.00
Medicare Xover - IP	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Nursing Facility	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - OP	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Other	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Physician	$0	$0	$0	$0.00	0	0	$0.00
Nursing Facility	$23,943,232	$770,942	$24,714,174	$1,563.87	166,418	126,368	$148.51
Outpatient - Other	$4,107,960	$21	$4,107,981	$259.95	8,676	6,588	$473.49
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$5,678,697	$13,753	$5,692,451	$360.21	98,875	75,080	$57.57
Physician - Clinic	$1,066,960	$0	$1,066,960	$67.52	161,515	122,645	$6.61
Physician - IP Mental Health	$3,293	$0	$3,293	$0.21	82	62	$40.15
Physician - OP Mental Health	$1,943,559	$25	$1,943,584	$122.99	85,561	64,970	$22.72
Physician - Other Practitioner	$800,307	$451	$800,758	$50.67	14,319	10,873	$55.92
Physician - PCP	$1,534,228	$168	$1,534,396	$97.09	27,210	20,662	$56.39
Physician - Specialist	$1,105,578	$64	$1,105,642	$69.96	21,253	16,138	$52.02
Pharmacy	$9,935,894	$0	$9,935,894	$628.73	178,019	135,177	$55.81
Transportation - Emergency	$556,508	$0	$556,508	$35.21	6,287	4,774	$88.52
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$76,473,425	$798,225	$77,271,649	$4,889.61	1,568,572		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.
Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID

Exhibit 1b

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Tidewater	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	16,367						
Service Type							
Adult Day Care	$20,349	$0	$20,349	$1.24	391	287	$52.04
Ambulatory Surgery Center	$26,633	$0	$26,633	$1.63	37	27	$719.82
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$1,907,299	$149	$1,907,449	$116.54	195,045	143,002	$9.78
DME/Supplies	$1,815,300	$503	$1,815,803	$110.94	15,440	11,320	$117.60
Emergency	$1,294,632	$90	$1,294,722	$79.10	1,954	1,433	$662.60
FQHC	$141,015	$2	$141,017	$8.62	1,891	1,386	$74.57
Home Health Services	$929,587	$0	$929,587	$56.80	2,468	1,809	$376.66
Inpatient - Medical/Surgical	$12,827,613	$0	$12,827,613	$783.74	1,206	884	$10,636.50
Inpatient - Psych	$95,432	$0	$95,432	$5.83	141	103	$676.82
Lab and X-ray Services	$539,412	$0	$539,412	$32.96	31,049	22,764	$17.37
Medicare Xover - IP	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Nursing Facility	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - OP	$13	$0	$13	$0.00	2	1	$6.63
Medicare Xover - Other	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - Physician	$20	$0	$20	$0.00	3	2	$6.62
Nursing Facility	$31,425,414	$2,186,408	$33,611,822	$2,053.61	213,417	156,472	$157.49
Outpatient - Other	$3,092,128	$713	$3,092,841	$188.97	5,099	3,738	$606.56
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$13,417,949	$47,438	$13,465,388	$822.71	182,010	133,445	$73.98
Physician - Clinic	$1,591,111	$0	$1,591,111	$97.21	246,576	180,783	$6.45
Physician - IP Mental Health	$600	$0	$600	$0.04	13	10	$46.18
Physician - OP Mental Health	$3,842,867	$378	$3,843,246	$234.81	229,190	168,036	$16.77
Physician - Other Practitioner	$1,256,845	$129	$1,256,974	$76.80	15,152	11,109	$82.96
Physician - PCP	$1,536,842	$82	$1,536,925	$93.90	32,983	24,182	$46.60
Physician - Specialist	$1,233,319	$111	$1,233,430	$75.36	22,462	16,469	$54.91
Pharmacy	$9,286,038	$0	$9,286,038	$567.36	156,535	114,768	$59.32
Transportation - Emergency	$468,316	$0	$468,316	$28.61	7,371	5,404	$63.53
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$86,748,736	$2,236,004	$88,984,740	$5,436.78	1,360,435		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.
Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID

Exhibit 1b

FY 2016 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
All Regions	Medicaid Payments FY13 - FY14	Patient Payments FY13 - FY14	Total Payments FY13 - FY14	Unadjusted PMPM	Units FY13 - FY14	Units/1000 FY13 - FY14	Cost/Unit FY13 - FY14
Member Months	67,268						
Service Type							
Adult Day Care	$711,407	$0	$711,407	$10.58	22,940	4,092	$31.01
Ambulatory Surgery Center	$85,263	$0	$85,263	$1.27	134	24	$636.29
Case Management Services	$1,855	$0	$1,855	$0.03	557	99	$3.33
Consumer Directed Services	$24,127,831	$18,714	$24,146,545	$358.96	2,369,099	422,625	$10.19
DME/Supplies	$6,944,653	$1,704	$6,946,357	$103.26	65,046	11,604	$106.79
Emergency	$4,265,097	$90	$4,265,187	$63.41	7,905	1,410	$539.56
FQHC	$511,176	$7	$511,183	$7.60	7,220	1,288	$70.80
Home Health Services	$3,263,942	$0	$3,263,942	$48.52	10,344	1,845	$315.54
Inpatient - Medical/Surgical	$59,840,560	$3,216	$59,843,775	$889.63	6,548	1,168	$9,139.24
Inpatient - Psych	$286,467	$0	$286,467	$4.26	425	76	$674.04
Lab and X-ray Services	$2,295,667	$0	$2,295,667	$34.13	133,406	23,798	$17.21
Medicare Xover - IP	$1,184	$0	$1,184	$0.02	1	0	$1,184.00
Medicare Xover - Nursing Facility	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - OP	$13	$0	$13	$0.00	2	0	$6.63
Medicare Xover - Other	$456	$0	$456	$0.01	18	3	$25.33
Medicare Xover - Physician	$29	$0	$29	$0.00	8	1	$3.69
Nursing Facility	$119,413,619	$5,954,467	$125,368,085	$1,863.71	781,710	139,450	$160.38
Outpatient - Other	$15,163,317	$734	$15,164,051	$225.43	26,147	4,664	$579.95
Outpatient - Psychological	$0	$0	$0	$0.00	0	0	$0.00
Personal Care Services	$39,365,086	$78,158	$39,443,244	$586.36	526,307	93,888	$74.94
Physician - Clinic	$5,752,859	$0	$5,752,859	$85.52	893,942	159,471	$6.44
Physician - IP Mental Health	$10,413	$0	$10,413	$0.15	200	36	$52.07
Physician - OP Mental Health	$11,722,144	$862	$11,723,006	$174.27	594,260	106,010	$19.73
Physician - Other Practitioner	$4,665,727	$614	$4,666,341	$69.37	62,506	11,150	$74.65
Physician - PCP	$6,443,569	$377	$6,443,947	$95.79	142,033	25,337	$45.37
Physician - Specialist	$5,165,484	$435	$5,165,919	$76.80	104,684	18,675	$49.35
Pharmacy	$38,615,667	$0	$38,615,667	$574.06	673,451	120,137	$57.34
Transportation - Emergency	$1,967,977	$0	$1,967,977	$29.26	28,205	5,032	$69.77
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$350,621,462	$6,059,378	$356,680,840	$5,302.37	6,457,098		

Note:
Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.
Acute care costs for the ALTC population are obtained from health plan reported encounter data.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Prescription Drug Adjustment

Exhibit 2a

		Dual Eligibles	Non-Dual Eligibles	Source
1.	Fee-for-Service Net Cost PMPM	$9.30	$574.06	DMAS FY13-FY14 FFS Invoices
2.	Fee-for-Service Net Cost per Script	$6.55	$57.34	DMAS FY13-FY14 FFS Invoices
3.	Average Fee-for-Service Copayment per Script	$0.02	$0.03	DMAS FY13-FY14 FFS Invoices
4.	Fee-for-Service Gross Cost per Script	$6.57	$57.37	= (2.) + (3.)
5.	Average Fee-for-Service Dispensing Fees	$3.20	$3.07	DMAS FY13-FY14 FFS Invoices
6.	Fee-for-Service Ingredient Cost per Script	$3.38	$54.30	= (4.) - (5.)
7.	Average Fee-for-Service Rebate	6%	36%	Provided by DMAS
8.	Fee-for-Service Cost per Script with Rebate	$3.16	$34.75	= (6.) * (1 - (7.))
9.	Brand-Generic Improvement Adjustment	1.000	0.995	VA Claims Analysis
10.	Adjusted Cost PMPM with Brand-Generic Improvement	$3.16	$34.58	= (8.) * (9.)
11.	Average Fee-for-Service Dispensing Fees	$3.20	$3.07	= (5.)
12.	Adjusted Cost per Script	$6.35	$37.65	= (10.) + (11.)
13.	Adjusted Cost PMPM	$9.02	$376.91	= (12.) * scripts / MM
14.	**Pharmacy Adjustment Factor**	**-3.0%**	**-34.3%**	= (13.) / (1.) -1

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Non-Emergency Transportation Adjustment

Exhibit 2b

	Adjustment Value	Source
Non-ER Transportation Rate	**$47.22**	From DMAS - Rates Effective October 1, 2014

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Adult Day Care Adjustment

Exhibit 2c

		Northern Virginia	Rest of State	Source
1.	Total Claims in Adult Day Care	$6,449,807	$5,269,486	DMAS FY13-FY14 FFS Invoices
2a.	Rates Effective Prior to 7/1/2013	$50.10	$45.65	Provided by DMAS
2b.	Rates Effective FY14	$60.10	$55.65	Provided by DMAS
2c.	% Change in rates	20.0%	21.9%	= (2b.) / (2a.) - 1
3a.	Claims Associated with Procedure Code S5102	$2,343,581	$2,587,858	DMAS FY13 FFS Invoices
3b.	Dollar Change	$467,781	$566,891	= (3a.) * (2c.)
4.	**Adult Day Care Adjustment**	**7.3%**	**10.8%**	= (3b.) / (1.)

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Hospital Inpatient Adjustment

Exhibit 2d

		Inpatient Medical/Surgical	Inpatient - Psych	Source
1a	FY13 Claims in IP Service Categories	$38,426,008	$420,736	DMAS FY13 FFS Invoices
1b	FY14 Claims in IP Service Categories	$38,862,253	$239,004	DMAS FY14 FFS Invoices
2.	FY13-14 Hospital Capital Percentage	10.2%	10.2%	Provided by DMAS
3a.	FY14 Hospital Rate Change	4.7%	-7.4%	Provided by DMAS
3b.	Dollar Change	$1,610,748	($27,830)	= (1a.) * (1 - (2.)) * (3a.)
4.	**Hospital Inpatient Adjustment**	**2.1%**	**-4.2%**	= (3b.) / ((1a.) + (1b.))

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Nursing Facility Adjustment

Exhibit 2e

	Adjustment Value	Source
1a. FY13 Claims in Nursing Facility Service Category	$912,726,216	FY13 FFS Invoices
1b. FY14 Claims in Nursing Facility Service Category	$937,528,751	FY14 FFS Invoices
2. FY13-14 Nursing Facility Capital Percentage	9.7%	Provided by DMAS
3a. FY15 Nursing Facility Capital Rental Rate Decrease	-3.2%	Provided by DMAS
3b. Dollar Change	($5,743,191)	= ((1a.) + (1b.)) * (2.) * (3a.)
4a. FY14 Nursing Facility Operating Rate Increase	1.1%	Provided by DMAS
4b. FY15 Nursing Facility Operating Rate Increase	3.2%	Provided by DMAS
4c. Dollar Change	$62,566,354	= (1a.) * (1 - (2.)) * ((1 + (4a.)) * (1 + (4b.)) - 1) + (1b.) * (1 - (2.)) * (4b.)
5a. FY14 Occupancy Requirement Change Impact	0.17%	Provided by DMAS
5b. Dollar Change (applied to FY13 Nursing Facility claims)	$1,551,635	= (1a.) * (5a.)
6a. Nursing Facility Cost Settlement Adjustment	4.5%	Provided by DMAS
6b. Dollar Change	$85,888,339	= ((1a.) + (1b.) + (3b.) + (4c.) + (5b.)) * (6a.)
7. Nursing Facility Adjustment	**7.8%**	= ((3b.) + (4c.) + (5b.) + (6b.)) / ((1a.) + (1b.))

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
DME Fees Adjustment

Exhibit 2f

		Adjustment Value	Source
1.	Claims Associated with DME/Supplies Service Category	$24,579,026	FY13-14 FFS Invoices
2.	Proportion of Claims subject to change	$1,518,458	Provided by DMAS
3a.	FY15 DME Fee Change	-33.7%	Provided by DMAS
3b.	Dollar Change	($511,751)	= (2.) * (3a.)
4.	**DME Fee Adjustment**	**-2.1%**	= (3b.) / (1.)

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Incontinence Supplies Adjustment

Exhibit 2g

		Dual Eligibles	Non-Dual Eligibles	Source
1.	Total Claims in DME Supplies	$17,634,373	$6,944,653	FY13-14 FFS Invoices
2.	Proportion of Claims Associated with Incontinence Supplies	$11,783,613	$650,734	FY13-14 FFS Invoices
3a.	Average Incontinence Supplies Rate Change	-31.8%	-33.5%	Provided by DMAS- Rates Effective FY16
3b.	Dollar Change	($3,744,220)	($218,289)	= (2.) * (3a.)
4.	**Incontinence Supplies Adjustment Factor**	**-21.2%**	**-3.1%**	= (3b.) / (1.)

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Lab Fee Adjustment

Exhibit 2h

	Adjustment Value	Source
1. Lab Fee Adjustment	**-12.0%**	Provided by DMAS - Rates Effective FY15

Virginia Medicaid

FY 2016 PACE Capitation Rate Development

ALTC / HAP Expansion - Health Plan Encounter Data

Hepatitis C Treatment Adjustment

Exhibit 2i

		ALTC Adult	Source
1.	Total Claims in Pharmacy Service Categories	$28,219,550	FY13-14 Health Plan Encounter Data
2.	Unique Individuals in Base Period	3,921	FY13-14 Health Plan Encounter Data
3a.	Proportion of Population Being Tested for Hepatitis C	5.3%	FY13-14 Health Plan Encounter Data
3b.	Number of Individuals Being Tested	209	FY13-14 Health Plan Encounter Data
3c.	Projected Testing Change in FY15	35%	Estimate
3d.	Additional Number of People Being Tested	73	= (3b.) * (3c.)
3e.	Average Cost Per Test Per Person	$61.70	FY13-14 Health Plan Encounter Data
4a.	Proportion of Population Diagnosed With Hepatitis C	6.2%	FY13-14 Health Plan Encounter Data
4b.	Number of Individuals Diagnosed With Hepatitis C	245	FY13-14 Health Plan Encounter Data
4c.	Projected Increase in People Diagnosed With Hepatitis C	5%	Estimate
4d.	Projected Number of People With Hepatitis C	257	= (4b.) * (1 + (4c.))
5a.	Proportion of People With Hepatitis C With Drug Therapy	1.6%	FY13-14 Health Plan Encounter Data
5b.	Number of Individuals With Hepatitis C With Drug Therapy in Base Period	4	FY13-14 Health Plan Encounter Data
5c.	Increase in Proportion of Hepatitis C Receiving Drug Therapy	30%	Estimate
5d.	Projected Number of Additional People Going Through Drug Therapy	1	= (4d.) * (5a.) * (1 + (5c.)) - (5b.)
5e.	Average Cost of Current Drug Therapy	$60,000	FY13-14 Health Plan Encounter Data
5f.	Average Cost of New Drug Therapy	$90,000	Estimate
6.	Additional Cost of Hepatitis C Treatment	$255,913	= ((3d.) * (3e.)) + ((5f.) - (5e.)) * (5b.) + (5d.) * (5f.)
7.	**Hepatitis C Treatment Adjustment**	**0.9%**	= (6.) / (1.)

Note: Based on analysis of FY13 - FY14 base data experience

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Emergency Room Triage Adjustment

Exhibit 2j

		Non-Dual Eligibles	Source
1.	Total Claims in Physician - Other Practitioner, PCP, Specialist	$16,274,780	FY13-14 FFS Invoices
2	FY13-14 Number of Claims in ER Triage Level 3	510	FY13-14 FFS Invoices
3.	ER Cost No Triage Level 3	$43.57	Provided by DMAS
4.	ER Triage Cost	$22.06	Provided by DMAS
5.	FY16 ER Triage Financial Impact (2 years)	$10,970	= (2.) * ((3.) - (4.))
6.	**FY16 ER Triage Adjustment**	**0.07%**	= (5.) / (1.)

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Resource Based Relative Value Scale Adjustment

Exhibit 2k

		Adjustment Value	Source
1.	Professional Fee Adjustment - Effective FY16	0.5%	Provided by DMAS
2.	Proportion of claims subject to fee adjustment	99%	FY13-14 FFS Invoices
3.	**Final Professional Fee Adjustment**	**0.5%**	= (1.) * (2.)

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Personal Care and Respite Care Adjustment

Exhibit 2l

			Adjustment Value	Source
1.	Total Claims in Service Categories	a. Consumer Directed Services	$199,461,576	FY13-14 FFS Invoices
		b. Personal Care Services	$416,487,862	FY13-14 FFS Invoices
		c. Physician - OP Mental Health	$84,722,086	FY13-14 FFS Invoices
2.	FY16 Fee Change		2.0%	Provided by DMAS
3.	Claims associated with FY16 Fee Change	a. Consumer Directed Services	$199,344,540	FY13-14 FFS Invoices
		b. Personal Care Services	$416,483,441	FY13-14 FFS Invoices
		c. Physician - OP Mental Health	$70,114,776	FY13-14 FFS Invoices
4.	**Personal Care and Respite Care Adjustment**	**a.** Consumer Directed Services	**2.0%**	= ((3a.) * (2.) / (1a.)
		b. Personal Care Services	**2.0%**	= ((3b.) * (2.) / (1b.)
		c. Physician - OP Mental Health	**1.7%**	= ((3c.) * (2.) / (1c.)

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Other Adjustments

Exhibit 2m

		Adjustment Values	Source
1.	**Managed Care Utilization Savings**	**-18.4%**	American Academy of Actuaries
2.	**Administrative Cost**	**15.0%**	Provided by DMAS

Virginia Medicaid

Exhibit 3a

FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
IBNR, Policy/Program, and Trend Adjustments for Dual Population

	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
Category of Service	**IBNR**	**Policy/ Program**	**Total Base Data Adjustments**	**Cost Trend**	**Utilization Trend**	**Cost and Utilization Trend**		
Nursing Facility	0.0%	7.8%	7.8%	0.6%	-2.1%	-1.5%	0.0%	0.9848
Adult Day Care	0.1%	8.9%	8.9%	-10.1%	14.6%	3.1%	2.7%	1.0733
Personal Care	0.0%	2.0%	2.0%	3.4%	-0.2%	3.2%	3.1%	1.0811
Consumer Directed Services	0.0%	2.0%	2.0%	-0.9%	8.7%	7.7%	12.6%	1.2866
IP Medical/Surgical - DRG Services	0.4%	2.1%	2.5%	2.0%	-13.4%	-11.7%	0.0%	0.8826
IP Psych - Per Diem Services	0.0%	-4.2%	-4.2%	2.0%	-13.4%	-11.7%	0.0%	0.8826
Outpatient Hospital	0.1%	0.0%	0.1%	-11.1%	-1.4%	-12.4%	0.0%	0.8759
Practitioner	0.1%	2.0%	2.1%	1.7%	2.6%	4.3%	4.8%	1.1188
Prescription Drug	0.0%	-3.0%	-3.0%	-1.6%	-6.7%	-8.2%	0.0%	0.9182
Other	0.1%	-23.2%	-23.1%	7.7%	1.2%	9.0%	1.3%	1.1117
Weighted Average*	0.0%	6.1%	6.1%	1.0%	-0.9%	0.0%	1.5%	1.0236
Medicare Crossovers								
Inpatient	0.2%	0.0%	0.2%	-1.1%	4.7%	3.5%	5.3%	1.1188
Nursing Facility	0.2%	0.0%	0.2%	-1.1%	4.7%	3.5%	5.3%	1.1188
Outpatient	0.2%	0.0%	0.2%	-1.1%	4.7%	3.5%	5.3%	1.1188
Professional	0.2%	0.0%	0.2%	-1.1%	4.7%	3.5%	5.3%	1.1188
Other	0.2%	0.0%	0.2%	-1.1%	4.7%	3.5%	5.3%	1.1188
Weighted Average*	0.2%	0.0%	0.2%	-1.1%	4.7%	3.5%	5.3%	1.1188
Months of Trend Applied:				12	12	12	18	

Notes:

Trend rates are calculated based on regression studies of historical Virginia fee-for-service data. Contract period trend for Nursing Home, Adult Day Care, and Personal Care categories also considers DMAS budget projections.

Trend rates have been calculated separately for the broad service categories shown above.

Regressions were based on PMPM costs. Trends for Long Term Care Services were developed from historical data and DMAS budget information.

The following categories include patient payments: Nursing Facility, Adult Day Care, Personal Care, Consumer Directed Services, and Medicare Crossover - Nursing Facility.

Data period trend are applied from the midpoint of the data period to the end of the data period using compound interest calculations. Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest.

Total Trend & IBNR = [(1 + Data Period Trend) ^ (months/12) * (1+ Contract Period Utilization Trend) ^ (months/12) * (1 + IBNR Adjustment)]

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY 2013-2014 Claims)

Virginia Medicaid

Exhibit 3b

FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
IBNR, Policy/Program, and Trend Adjustments for Non-Dual Population

	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
Category of Service	**IBNR**	**Policy/ Program**	**Total Base Data Adjustments**	**Cost Trend**	**Utilization Trend**	**Cost and Utilization Trend**		
Nursing Facility	0.0%	7.8%	7.8%	0.4%	-5.3%	-4.9%	0.0%	0.9507
Adult Day Care	0.1%	10.2%	10.3%	-10.1%	14.6%	3.1%	2.7%	1.0733
Personal Care	0.0%	2.0%	2.0%	3.4%	-0.2%	3.2%	3.1%	1.0811
Consumer Directed Services	0.0%	2.0%	2.0%	-0.9%	8.7%	7.7%	12.6%	1.2866
IP Medical/Surgical - DRG Services	0.1%	2.1%	2.2%	-11.2%	7.5%	-4.6%	0.0%	0.9544
IP Psych - Per Diem Services	0.0%	-4.2%	-4.2%	-11.2%	7.5%	-4.6%	0.0%	0.9544
Outpatient Hospital	0.3%	0.0%	0.3%	-16.4%	23.2%	3.0%	2.7%	1.0722
Practitioner	0.1%	1.1%	1.2%	7.0%	-11.1%	-4.9%	5.1%	1.0247
Prescription Drug	0.0%	-33.4%	-33.4%	8.8%	-4.3%	4.2%	0.1%	1.0436
Other	0.1%	-5.7%	-5.6%	-4.3%	-4.9%	-9.0%	0.0%	0.9100
Weighted Average*	0.1%	0.7%	0.7%	-1.2%	-0.2%	-1.9%	1.9%	1.0088
Months of Trend Applied:				12	12	12	18	

Notes:

Trend rates are calculated based on regression studies of historical Virginia fee-for-service data. Contract period trend for Nursing Home, Adult Day Care, and Personal Care categories also considers DMAS budget projections.

Trend rates have been calculated separately for the broad service categories shown above.

Regressions were based on PMPM costs. Trends for Long Term Care Services were developed from historical data and DMAS budget information.

The following categories include patient payments: Nursing Facility, Adult Day Care, Personal Care, Consumer Directed Services, and Medicare Crossover - Nursing Facility.

Data period trend are applied from the midpoint of the data period to the end of the data period using compound interest calculations. Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest.

Total Trend & IBNR = [(1 + Data Period Trend) ^ (months/12) * (1+ Contract Period Utilization Trend) ^ (months/12) * (1 + IBNR Adjustment)]

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY 2013-2014 Claims)

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
Northern Virginia	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$6,343,331	$4,192	$41,918	$463,403	$6,852,843	1.073	$7,355,026	$63.69	0.82	$51.97
Ambulatory Surgery Center	$1,817	$1			$1,818	1.119	$2,034	$0.02	0.82	$0.01
Case Management Services	$0	$0			$0	1.119	$0	$0.00	0.82	$0.00
Consumer Directed Services	$27,269,897	$1,657	$194,647	$549,002	$28,015,203	1.287	$36,045,412	$312.13	0.82	$254.70
DME/Supplies	$3,151,630	$2,276		($735,320)	$2,418,586	1.112	$2,688,801	$23.28	0.82	$19.00
Emergency	$6,117	$8			$6,125	0.876	$5,365	$0.05	0.82	$0.04
FQHC	$71	$0			$71	1.119	$79	$0.00	0.82	$0.00
Home Health Services	$28,099	$37			$28,136	0.876	$24,645	$0.21	0.82	$0.17
Inpatient - Medical/Surgical	$8,168,071	$32,951		$170,916	$8,371,937	0.883	$7,388,850	$63.98	0.82	$52.21
Inpatient - Psych	$350,434	$0		($14,782)	$335,652	0.883	$296,237	$2.57	0.82	$2.09
Lab and X-ray Services	$13,574	$10		($1,630)	$11,953	1.112	$13,289	$0.12	0.82	$0.09
Medicare Xover - IP	$2,515,260	$4,614			$2,519,874	1.119	$2,819,224	$24.41	0.82	$19.92
Medicare Xover - Nursing Facility	$1,664,990	$3,054	$25,322		$1,693,367	1.119	$1,894,531	$16.41	0.82	$13.39
Medicare Xover - OP	$1,455,783	$2,670			$1,458,453	1.119	$1,631,711	$14.13	0.82	$11.53
Medicare Xover - Other	$801,204	$1,470			$802,674	1.119	$898,028	$7.78	0.82	$6.35
Medicare Xover - Physician	$3,580,023	$6,567			$3,586,590	1.119	$4,012,661	$34.75	0.82	$28.35
Nursing Facility	$227,799,083	$55,229	$50,717,127	$17,765,648	$296,337,086	0.985	$291,836,410	$2,527.09	0.82	$2,062.11
Outpatient - Other	$827,624	$1,094			$828,718	0.876	$725,870	$6.29	0.82	$5.13
Outpatient - Psychological	$0	$0			$0	0.876	$0	$0.00	0.82	$0.00
Personal Care Services	$120,205,562	$22,721	445532.7162	$2,413,451	$123,087,266	1.081	$133,067,976	$1,152.27	0.82	$940.26
Physician - Clinic	$16,886	$10		$87	$16,983	1.119	$19,000	$0.16	0.82	$0.13
Physician - IP Mental Health	$6,276	$4		$32	$6,312	1.119	$7,062	$0.06	0.82	$0.05
Physician - OP Mental Health	$19,095,340	$11,625		$414,275	$19,521,240	1.119	$21,839,776	$189.12	0.82	$154.32
Physician - Other Practitioner	$761,262	$463		$3,908	$765,633	1.119	$856,568	$7.42	0.82	$6.05
Physician - PCP	$74,376	$45		$382	$74,803	1.119	$83,687	$0.72	0.82	$0.59
Physician - Specialist	$43,349	$26		$223	$43,598	1.119	$48,777	$0.42	0.82	$0.34
Pharmacy	$1,009,988	$63		($30,513)	$979,537	0.918	$899,412	$7.79	1.00	$7.79
Transportation - Emergency	$5,555	$4			$5,559	1.112	$6,180	$0.05	0.82	$0.04
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$425,195,601	$150,790	$51,424,547	$20,999,079	$497,770,017			$4,502.13		$3,683.86
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$4,593.05		$4,325.62

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
Other MSA	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$552,252	$365	$17,966	$61,383	$631,966	1.073	$678,278	$4.97	0.82	$4.06
Ambulatory Surgery Center	$1,545	$1			$1,546	1.119	$1,729	$0.01	0.82	$0.01
Case Management Services	$0	$0			$0	1.119	$0	$0.00	0.82	$0.00
Consumer Directed Services	$30,392,902	$1,846	$263,393	$612,803	$31,270,945	1.287	$40,234,372	$295.00	0.82	$240.72
DME/Supplies	$2,191,431	$1,582		($511,292)	$1,681,721	1.112	$1,869,611	$13.71	0.82	$11.19
Emergency	$5,036	$7			$5,042	0.876	$4,416	$0.03	0.82	$0.03
FQHC	$2,425	$1			$2,426	1.119	$2,714	$0.02	0.82	$0.02
Home Health Services	$7,436	$10			$7,445	0.876	$6,521	$0.05	0.82	$0.04
Inpatient - Medical/Surgical	$2,284,077	$9,214		$47,794	$2,341,085	0.883	$2,066,180	$15.15	0.82	$12.36
Inpatient - Psych	$14,259	$0		($601)	$13,658	0.883	$12,054	$0.09	0.82	$0.07
Lab and X-ray Services	$17,678	$13		($2,123)	$15,568	1.112	$17,307	$0.13	0.82	$0.10
Medicare Xover - IP	$3,445,425	$6,320			$3,451,745	1.119	$3,861,797	$28.31	0.82	$23.10
Medicare Xover - Nursing Facility	$2,068,876	$3,795	$65,380		$2,138,051	1.119	$2,392,043	$17.54	0.82	$14.31
Medicare Xover - OP	$1,362,294	$2,499			$1,364,793	1.119	$1,526,924	$11.20	0.82	$9.14
Medicare Xover - Other	$1,232,868	$2,261			$1,235,129	1.119	$1,381,857	$10.13	0.82	$8.27
Medicare Xover - Physician	$3,817,755	$7,003			$3,824,757	1.119	$4,279,123	$31.37	0.82	$25.60
Nursing Facility	$298,721,225	$72,424	$72,293,847	$23,296,740	$394,384,235	0.985	$388,394,450	$2,847.73	0.82	$2,323.74
Outpatient - Other	$83,485	$110			$83,596	0.876	$73,221	$0.54	0.82	$0.44
Outpatient - Psychological	$0	$0			$0	0.876	$0	$0.00	0.82	$0.00
Personal Care Services	$35,029,116	$6,621	408346.4723	$708,874	$36,152,957	1.081	$39,084,472	$286.57	0.82	$233.84
Physician - Clinic	$6,673	$4		$34	$6,711	1.119	$7,509	$0.06	0.82	$0.04
Physician - IP Mental Health	$463	$0		$2	$465	1.119	$521	$0.00	0.82	$0.00
Physician - OP Mental Health	$8,622,654	$5,249		$187,069	$8,814,973	1.119	$9,861,926	$72.31	0.82	$59.00
Physician - Other Practitioner	$1,216,690	$741		$6,246	$1,223,676	1.119	$1,369,012	$10.04	0.82	$8.19
Physician - PCP	$38,349	$23		$197	$38,569	1.119	$43,150	$0.32	0.82	$0.26
Physician - Specialist	$33,915	$21		$174	$34,110	1.119	$38,161	$0.28	0.82	$0.23
Pharmacy	$1,422,708	$89		($42,982)	$1,379,814	0.918	$1,266,947	$9.29	1.00	$9.29
Transportation - Emergency	$9,742	$7			$9,749	1.112	$10,838	$0.08	0.82	$0.06
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$392,581,275	$120,206	$73,048,933	$24,364,319	$490,114,733			$3,702.14		$3,031.34
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$3,776.73		$3,557.95

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

Exhibit 4a

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$3,202,917	$2,116	$76,135	$352,988	$3,634,156	1.073	$3,900,471	$28.24	0.82	$23.04
Ambulatory Surgery Center	$1,299	$1			$1,300	1.119	$1,455	$0.01	0.82	$0.01
Case Management Services	$0	$0			$0	1.119	$0	$0.00	0.82	$0.00
Consumer Directed Services	$40,806,304	$2,479	$443,677	$824,565	$42,077,025	1.287	$54,137,880	$391.97	0.82	$319.84
DME/Supplies	$3,951,637	$2,854		($921,973)	$3,032,518	1.112	$3,371,323	$24.41	0.82	$19.92
Emergency	$11,095	$15			$11,109	0.876	$9,731	$0.07	0.82	$0.06
FQHC	$655	$0			$656	1.119	$733	$0.01	0.82	$0.00
Home Health Services	$14,458	$19			$14,477	0.876	$12,680	$0.09	0.82	$0.07
Inpatient - Medical/Surgical	$2,170,378	$8,756		$45,415	$2,224,549	0.883	$1,963,328	$14.21	0.82	$11.60
Inpatient - Psych	$0	$0			$0	0.883	$0	$0.00	0.82	$0.00
Lab and X-ray Services	$13,576	$10		($1,630)	$11,955	1.112	$13,291	$0.10	0.82	$0.08
Medicare Xover - IP	$4,115,582	$7,549			$4,123,131	1.119	$4,612,942	$33.40	0.82	$27.25
Medicare Xover - Nursing Facility	$2,060,071	$3,779	$41,127		$2,104,977	1.119	$2,355,039	$17.05	0.82	$13.91
Medicare Xover - OP	$1,542,607	$2,830			$1,545,437	1.119	$1,729,028	$12.52	0.82	$10.22
Medicare Xover - Other	$1,227,669	$2,252			$1,229,921	1.119	$1,376,030	$9.96	0.82	$8.13
Medicare Xover - Physician	$4,606,415	$8,449			$4,614,864	1.119	$5,163,091	$37.38	0.82	$30.50
Nursing Facility	$261,185,854	$63,323	$69,346,357	$20,369,423	$350,964,957	0.985	$345,634,610	$2,502.44	0.82	$2,041.99
Outpatient - Other	$154,139	$204			$154,342	0.876	$135,188	$0.98	0.82	$0.80
Outpatient - Psychological	$0	$0			$0	0.876	$0	$0.00	0.82	$0.00
Personal Care Services	$56,094,149	$10,603	677273.1099	$1,135,628	$57,917,653	1.081	$62,613,990	$453.33	0.82	$369.92
Physician - Clinic	$766	$0		$4	$770	1.119	$861	$0.01	0.82	$0.01
Physician - IP Mental Health	$1,879	$1		$10	$1,889	1.119	$2,114	$0.02	0.82	$0.01
Physician - OP Mental Health	$10,893,316	$6,631		$236,332	$11,136,279	1.119	$12,458,934	$90.20	0.82	$73.61
Physician - Other Practitioner	$1,539,989	$937		$7,905	$1,548,832	1.119	$1,732,787	$12.55	0.82	$10.24
Physician - PCP	$62,540	$38		$321	$62,899	1.119	$70,370	$0.51	0.82	$0.42
Physician - Specialist	$43,624	$27		$224	$43,875	1.119	$49,086	$0.36	0.82	$0.29
Pharmacy	$1,209,515	$75		($36,542)	$1,173,049	0.918	$1,077,095	$7.80	1.00	$7.80
Transportation - Emergency	$5,591	$4			$5,595	1.112	$6,220	$0.05	0.82	$0.04
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$394,916,023	$122,953	$70,584,570	$22,012,670	$487,636,215			$3,684.87		$3,016.97
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$3,759.10		$3,541.05

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
Rural	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$562,145	$371	$1,975	$60,728	$625,220	1.073	$671,036	$3.20	0.82	$2.61
Ambulatory Surgery Center	$3,623	$2			$3,625	1.119	$4,056	$0.02	0.82	$0.02
Case Management Services	$18,698	$11			$18,709	1.119	$20,931	$0.10	0.82	$0.08
Consumer Directed Services	$62,847,246	$3,818	$423,830	$1,264,755	$64,539,649	1.287	$83,039,136	$395.97	0.82	$323.11
DME/Supplies	$4,532,144	$3,273		($1,057,413)	$3,478,003	1.112	$3,866,581	$18.44	0.82	$15.05
Emergency	$15,574	$21			$15,595	0.876	$13,659	$0.07	0.82	$0.05
FQHC	$9,897	$6			$9,903	1.119	$11,079	$0.05	0.82	$0.04
Home Health Services	$22,088	$29			$22,117	0.876	$19,372	$0.09	0.82	$0.08
Inpatient - Medical/Surgical	$2,642,895	$10,662		$55,302	$2,708,859	0.883	$2,390,767	$11.40	0.82	$9.30
Inpatient - Psych	$0	$0			$0	0.883	$0	$0.00	0.82	$0.00
Lab and X-ray Services	$29,911	$22		($3,592)	$26,341	1.112	$29,284	$0.14	0.82	$0.11
Medicare Xover - IP	$5,862,102	$10,753			$5,872,855	1.119	$6,570,525	$31.33	0.82	$25.57
Medicare Xover - Nursing Facility	$3,471,049	$6,367	$72,340		$3,549,756	1.119	$3,971,452	$18.94	0.82	$15.45
Medicare Xover - OP	$3,087,079	$5,663			$3,092,742	1.119	$3,460,147	$16.50	0.82	$13.46
Medicare Xover - Other	$2,239,431	$4,108			$2,243,539	1.119	$2,510,062	$11.97	0.82	$9.77
Medicare Xover - Physician	$6,076,587	$11,146			$6,087,734	1.119	$6,810,931	$32.48	0.82	$26.50
Nursing Facility	$349,446,941	$84,722	$81,977,092	$27,252,749	$458,761,503	0.985	$451,793,975	$2,154.39	0.82	$1,757.98
Outpatient - Other	$104,240	$138			$104,377	0.876	$91,424	$0.44	0.82	$0.36
Outpatient - Psychological	$0	$0			$0	0.876	$0	$0.00	0.82	$0.00
Personal Care Services	$72,841,097	$13,768	968176.4703	$1,476,445	$75,299,487	1.081	$81,405,255	$388.18	0.82	$316.76
Physician - Clinic	$37,164	$23		$191	$37,378	1.119	$41,817	$0.20	0.82	$0.16
Physician - IP Mental Health	$276	$0		$1	$278	1.119	$311	$0.00	0.82	$0.00
Physician - OP Mental Health	$15,130,241	$9,211		$328,252	$15,467,704	1.119	$17,304,802	$82.52	0.82	$67.33
Physician - Other Practitioner	$2,486,022	$1,513		$12,762	$2,500,297	1.119	$2,797,257	$13.34	0.82	$10.88
Physician - PCP	$111,971	$68		$575	$112,614	1.119	$125,989	$0.60	0.82	$0.49
Physician - Specialist	$66,309	$40		$340	$66,690	1.119	$74,611	$0.36	0.82	$0.29
Pharmacy	$1,985,760	$124		($59,993)	$1,925,890	0.918	$1,768,355	$8.43	1.00	$8.43
Transportation - Emergency	$24,219	$17			$24,237	1.112	$26,944	$0.13	0.82	$0.10
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$533,654,710	$165,876	$83,443,413	$29,331,102	$646,595,101			$3,236.50		$2,651.22
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$3,301.59		$3,110.75

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

Exhibit 4a

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population

Age 55 and Over										
Tidewater	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$347,242	$229	$1,176	$37,508	$386,155	1.073	$414,453	$3.06	0.82	$2.50
Ambulatory Surgery Center	$9,150	$6			$9,155	1.119	$10,243	$0.08	0.82	$0.06
Case Management Services	$0	$0			$0	1.119	$0	$0.00	0.82	$0.00
Consumer Directed Services	$14,017,396	$852	$136,280	$282,924	$14,437,452	1.287	$18,575,768	$137.19	0.82	$111.95
DME/Supplies	$3,807,533	$2,750		($888,351)	$2,921,931	1.112	$3,248,382	$23.99	0.82	$19.58
Emergency	$5,047	$7			$5,054	0.876	$4,427	$0.03	0.82	$0.03
FQHC	$453	$0			$453	1.119	$507	$0.00	0.82	$0.00
Home Health Services	$17,661	$23			$17,684	0.876	$15,489	$0.11	0.82	$0.09
Inpatient - Medical/Surgical	$2,182,280	$8,804		$45,664	$2,236,747	0.883	$1,974,094	$14.58	0.82	$11.90
Inpatient - Psych	$8,580	$0		($362)	$8,218	0.883	$7,253	$0.05	0.82	$0.04
Lab and X-ray Services	$12,861	$9		($1,544)	$11,326	1.112	$12,591	$0.09	0.82	$0.08
Medicare Xover - IP	$3,446,548	$6,322			$3,452,870	1.119	$3,863,057	$28.53	0.82	$23.28
Medicare Xover - Nursing Facility	$1,450,486	$2,661	$55,402		$1,508,548	1.119	$1,687,757	$12.47	0.82	$10.17
Medicare Xover - OP	$1,583,640	$2,905			$1,586,545	1.119	$1,775,020	$13.11	0.82	$10.70
Medicare Xover - Other	$1,216,276	$2,231			$1,218,507	1.119	$1,363,260	$10.07	0.82	$8.22
Medicare Xover - Physician	$4,970,851	$9,118			$4,979,969	1.119	$5,571,569	$41.15	0.82	$33.58
Nursing Facility	$242,357,698	$58,758	$71,041,659	$18,901,048	$332,359,164	0.985	$327,311,396	$2,417.40	0.82	$1,972.60
Outpatient - Other	$49,718	$66			$49,784	0.876	$43,605	$0.32	0.82	$0.26
Outpatient - Psychological	$0	$0			$0	0.876	$0	$0.00	0.82	$0.00
Personal Care Services	$92,952,852	$17,570	929568.7523	$1,877,980	$95,777,970	1.081	$103,544,266	$764.74	0.82	$624.03
Physician - Clinic	$28	$0		$0	$28	1.119	$31	$0.00	0.82	$0.00
Physician - IP Mental Health	$0	$0			$0	1.119	$0	$0.00	0.82	$0.00
Physician - OP Mental Health	$19,258,391	$11,724		$417,813	$19,687,927	1.119	$22,026,261	$162.68	0.82	$132.74
Physician - Other Practitioner	$740,894	$451		$3,803	$745,148	1.119	$833,649	$6.16	0.82	$5.02
Physician - PCP	$44,238	$27		$227	$44,492	1.119	$49,776	$0.37	0.82	$0.30
Physician - Specialist	$51,871	$32		$266	$52,169	1.119	$58,365	$0.43	0.82	$0.35
Pharmacy	$1,208,656	$75		($36,516)	$1,172,216	0.918	$1,076,330	$7.95	1.00	$7.95
Transportation - Emergency	$3,804	$3			$3,807	1.112	$4,232	$0.03	0.82	$0.03
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$389,744,154	$124,621	$72,164,086	$20,640,460	$482,673,321			$3,691.82		$3,022.67
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$3,766.20		$3,547.75

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
All Regions	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$11,007,886	$7,274	$139,171	$976,009	$12,130,341	1.073	$13,019,263	$17.71	0.82	$14.45
Ambulatory Surgery Center	$17,434	$11			$17,444	1.119	$19,516	$0.03	0.82	$0.02
Case Management Services	$18,698	$11			$18,709	1.119	$20,931	$0.03	0.82	$0.02
Consumer Directed Services	$175,333,745	$10,652	$1,461,827	$3,534,050	$180,340,273	1.287	$232,032,568	$315.65	0.82	$257.57
DME/Supplies	$17,634,373	$12,734		($4,114,348)	$13,532,759	1.112	$15,044,697	$20.47	0.82	$16.70
Emergency	$42,869	$57			$42,925	0.876	$37,598	$0.05	0.82	$0.04
FQHC	$13,501	$8			$13,509	1.119	$15,113	$0.02	0.82	$0.02
Home Health Services	$89,741	$119			$89,860	0.876	$78,708	$0.11	0.82	$0.09
Inpatient - Medical/Surgical	$17,447,701	$70,386		$365,091	$17,883,178	0.883	$15,783,220	$21.47	0.82	$17.52
Inpatient - Psych	$373,273	$0		($15,746)	$357,527	0.883	$315,544	$0.43	0.82	$0.35
Lab and X-ray Services	$87,600	$63		($10,520)	$77,143	1.112	$85,762	$0.12	0.82	$0.10
Medicare Xover - IP	$19,384,918	$35,557			$19,420,475	1.119	$21,727,546	$29.56	0.82	$24.12
Medicare Xover - Nursing Facility	$10,715,471	$19,655	$259,572		$10,994,698	1.119	$12,300,823	$16.73	0.82	$13.65
Medicare Xover - OP	$9,031,403	$16,566			$9,047,969	1.119	$10,122,830	$13.77	0.82	$11.24
Medicare Xover - Other	$6,717,448	$12,322			$6,729,769	1.119	$7,529,238	$10.24	0.82	$8.36
Medicare Xover - Physician	$23,051,631	$42,283			$23,093,914	1.119	$25,837,375	$35.15	0.82	$28.68
Nursing Facility	$1,379,510,800	$334,456	$345,376,081	$107,585,607	$1,832,806,945	0.985	$1,804,970,840	$2,455.42	0.82	$2,003.62
Outpatient - Other	$1,219,205	$1,612			$1,220,817	0.876	$1,069,307	$1.45	0.82	$1.19
Outpatient - Psychological	$0	$0			$0	0.876	$0	$0.00	1.00	$0.00
Personal Care Services	$377,122,776	$71,282	$3,428,898	$7,612,378	$388,235,334	1.081	$419,715,958	$570.97	0.82	$465.91
Physician - Clinic	$61,517	$37		$316	$61,870	1.119	$69,219	$0.09	0.82	$0.08
Physician - IP Mental Health	$8,894	$5		$46	$8,945	1.119	$10,007	$0.01	0.82	$0.01
Physician - OP Mental Health	$72,999,942	$44,440		$1,583,741	$74,628,122	1.119	$83,491,699	$113.58	0.82	$92.68
Physician - Other Practitioner	$6,744,857	$4,106		$34,623	$6,783,587	1.119	$7,589,273	$10.32	0.82	$8.42
Physician - PCP	$331,473	$202		$1,702	$333,377	1.119	$372,972	$0.51	0.82	$0.41
Physician - Specialist	$239,069	$146		$1,227	$240,442	1.119	$268,999	$0.37	0.82	$0.30
Pharmacy	$6,836,627	$427		($206,546)	$6,630,507	0.918	$6,088,139	$8.28	1.00	$8.28
Transportation - Emergency	$48,911	$35			$48,946	1.112	$54,414	$0.07	0.82	$0.06
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$2,136,091,763	$684,445	$350,665,549	$117,347,630	$2,604,789,388			$3,689.83		$3,021.12
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$3,764.17		$3,545.92

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Trend Adjustment application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
Northern Virginia	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$106,477	$70		$7,727	$114,275	1.073	$122,649	$10.50	0.82	$8.57
Ambulatory Surgery Center	$9,230	$8			$9,237	1.025	$9,466	$0.81	0.82	$0.66
Case Management Services	$0	$0			$0	1.025	$0	$0.00	0.82	$0.00
Consumer Directed Services	$4,227,417	$257	($638)	$84,491	$4,311,527	1.287	$5,547,372	$474.76	0.82	$387.41
DME/Supplies	$867,924	$902		($45,399)	$823,428	0.910	$749,321	$64.13	0.82	$52.33
Emergency	$650,250	$1,702			$651,952	1.072	$699,041	$59.83	0.82	$48.82
FQHC	$11,220	$10			$11,229	1.025	$11,507	$0.98	0.82	$0.80
Home Health Services	$455,557	$1,192			$456,749	1.072	$489,739	$41.91	0.82	$34.20
Inpatient - Medical/Surgical	$10,728,478	$10,178		$223,802	$10,962,458	0.954	$10,462,622	$895.43	0.82	$730.67
Inpatient - Psych	$4,129	$0		($174)	$3,955	0.954	$3,775	$0.32	0.82	$0.26
Lab and X-ray Services	$400,689	$416		($48,133)	$352,972	0.910	$321,206	$27.49	0.82	$22.43
Medicare Xover - IP	$1,184	$0			$1,184	1.000	$1,184	$0.10	1.00	$0.10
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - OP	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Other	$456	$0			$456	1.000	$456	$0.04	1.00	$0.04
Medicare Xover - Physician	$6	$0			$6	1.000	$6	$0.00	1.00	$0.00
Nursing Facility	$24,157,612	$11,783	$1,354,977	$1,884,471	$27,408,843	0.951	$26,057,037	$2,230.06	0.82	$1,819.73
Outpatient - Other	$2,658,083	$6,956			$2,665,039	1.072	$2,857,528	$244.56	0.82	$199.56
Outpatient - Psychological	$0	$0			$0	1.072	$0	$0.00	0.82	$0.00
Personal Care Services	$11,824,059	$2,235	7975.2981	$236,683	$12,070,953	1.081	$13,049,743	$1,116.84	0.82	$911.35
Physician - Clinic	$1,139,830	$965		$5,852	$1,146,648	1.025	$1,174,997	$100.56	0.82	$82.06
Physician - IP Mental Health	$1,651	$1		$8	$1,661	1.025	$1,702	$0.15	0.82	$0.12
Physician - OP Mental Health	$2,371,895	$2,009		$51,471	$2,425,375	1.025	$2,485,338	$212.70	0.82	$173.57
Physician - Other Practitioner	$814,093	$690		$4,729	$819,512	1.025	$839,773	$71.87	0.82	$58.65
Physician - PCP	$1,290,693	$1,093		$7,498	$1,299,284	1.025	$1,331,407	$113.95	0.82	$92.98
Physician - Specialist	$984,874	$834		$5,721	$991,430	1.025	$1,015,941	$86.95	0.82	$70.95
Pharmacy	$6,627,803	$342		($2,216,180)	$4,411,964	1.044	$4,604,445	$394.07	1.00	$394.07
Transportation - Emergency	$222,240	$231			$222,471	0.910	$202,449	$17.33	0.82	$14.14
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$69,555,850	$41,874	$1,362,314	$202,569	$71,162,607			$6,212.56		$5,150.67
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$6,338.38		$6,051.28

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
Other MSA	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$80,798	$53		$8,698	$89,550	1.073	$96,112	$10.03	0.82	$8.18
Ambulatory Surgery Center	$16,618	$14			$16,632	1.025	$17,043	$1.78	0.82	$1.45
Case Management Services	$0	$0			$0	1.025	$0	$0.00	0.82	$0.00
Consumer Directed Services	$3,689,017	$224	$1,662	$73,775	$3,764,678	1.287	$4,843,776	$505.36	0.82	$412.38
DME/Supplies	$1,046,649	$1,088		($54,748)	$992,989	0.910	$903,622	$94.28	0.82	$76.93
Emergency	$449,476	$1,176			$450,653	1.072	$483,202	$50.41	0.82	$41.14
FQHC	$50,230	$43			$50,273	1.025	$51,516	$5.37	0.82	$4.39
Home Health Services	$403,877	$1,057			$404,934	1.072	$434,181	$45.30	0.82	$36.96
Inpatient - Medical/Surgical	$9,491,747	$9,005		$198,003	$9,698,755	0.954	$9,256,538	$965.76	0.82	$788.06
Inpatient - Psych	$53,073	$0		($2,239)	$50,834	0.954	$48,516	$5.06	0.82	$4.13
Lab and X-ray Services	$357,586	$372		($42,955)	$315,003	0.910	$286,653	$29.91	0.82	$24.40
Medicare Xover - IP	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - OP	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Other	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Physician	$4	$0			$4	1.000	$4	$0.00	1.00	$0.00
Nursing Facility	$18,193,257	$8,874	$706,450	$1,419,208	$20,327,789	0.951	$19,325,221	$2,016.25	0.82	$1,645.26
Outpatient - Other	$2,012,652	$5,267			$2,017,919	1.072	$2,163,669	$225.74	0.82	$184.20
Outpatient - Psychological	$0	$0			$0	1.072	$0	$0.00	0.82	$0.00
Personal Care Services	$2,936,067	$555	3830.8796	$58,808	$2,999,261	1.081	$3,242,460	$338.29	0.82	$276.05
Physician - Clinic	$588,385	$498		$3,021	$591,904	1.025	$606,538	$63.28	0.82	$51.64
Physician - IP Mental Health	$1,588	$1		$8	$1,597	1.025	$1,637	$0.17	0.82	$0.14
Physician - OP Mental Health	$1,321,823	$1,120		$28,684	$1,351,627	1.025	$1,385,044	$144.51	0.82	$117.92
Physician - Other Practitioner	$656,461	$556		$3,813	$660,830	1.025	$677,168	$70.65	0.82	$57.65
Physician - PCP	$999,260	$846		$5,805	$1,005,912	1.025	$1,030,781	$107.54	0.82	$87.76
Physician - Specialist	$816,080	$691		$4,741	$821,512	1.025	$841,823	$87.83	0.82	$71.67
Pharmacy	$5,959,495	$307		($1,992,714)	$3,967,088	1.044	$4,140,160	$431.95	1.00	$431.95
Transportation - Emergency	$369,813	$384			$370,197	0.910	$336,880	$35.15	0.82	$28.68
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$49,493,956	$32,132	$711,943	($288,091)	$49,949,940			$5,281.85		$4,398.16
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$5,388.68		$5,165.97

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$496,159	$328		$53,412	$549,899	1.073	$590,196	$42.68	0.82	$34.83
Ambulatory Surgery Center	$12,258	$10			$12,268	1.025	$12,572	$0.91	0.82	$0.74
Case Management Services	$0	$0			$0	1.025	$0	$0.00	0.82	$0.00
Consumer Directed Services	$7,116,813	$432	$6,649	$142,394	$7,266,289	1.287	$9,349,080	$676.07	0.82	$551.67
DME/Supplies	$1,455,789	$1,513		($76,149)	$1,381,153	0.910	$1,256,852	$90.89	0.82	$74.16
Emergency	$931,284	$2,437			$933,721	1.072	$1,001,162	$72.40	0.82	$59.08
FQHC	$74,635	$63			$74,698	1.025	$76,545	$5.54	0.82	$4.52
Home Health Services	$524,484	$1,372			$525,856	1.072	$563,837	$40.77	0.82	$33.27
Inpatient - Medical/Surgical	$12,672,788	$12,023		$264,361	$12,949,172	0.954	$12,358,751	$893.71	0.82	$729.27
Inpatient - Psych	$116,951	$0		($4,933)	$112,017	0.954	$106,910	$7.73	0.82	$6.31
Lab and X-ray Services	$437,835	$455		($52,595)	$385,695	0.910	$350,983	$25.38	0.82	$20.71
Medicare Xover - IP	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - OP	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Other	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Physician	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Nursing Facility	$21,694,103	$10,581	$935,689	$1,692,300	$24,332,674	0.951	$23,132,585	$1,672.81	0.82	$1,365.01
Outpatient - Other	$3,292,494	$8,616			$3,301,110	1.072	$3,539,542	$255.96	0.82	$208.86
Outpatient - Psychological	$0	$0			$0	1.072	$0	$0.00	0.82	$0.00
Personal Care Services	$5,508,313	$1,041	5160.0396	$110,289	$5,624,803	1.081	$6,080,899	$439.73	0.82	$358.82
Physician - Clinic	$1,366,574	$1,158		$7,017	$1,374,748	1.025	$1,408,737	$101.87	0.82	$83.13
Physician - IP Mental Health	$3,282	$3		$17	$3,301	1.025	$3,383	$0.24	0.82	$0.20
Physician - OP Mental Health	$2,241,999	$1,899		$48,652	$2,292,550	1.025	$2,349,229	$169.88	0.82	$138.62
Physician - Other Practitioner	$1,138,021	$964		$6,611	$1,145,596	1.025	$1,173,919	$84.89	0.82	$69.27
Physician - PCP	$1,082,545	$917		$6,289	$1,089,751	1.025	$1,116,693	$80.75	0.82	$65.89
Physician - Specialist	$1,025,632	$869		$5,958	$1,032,459	1.025	$1,057,985	$76.51	0.82	$62.43
Pharmacy	$6,806,437	$351		($2,275,911)	$4,530,877	1.044	$4,728,545	$341.94	1.00	$341.94
Transportation - Emergency	$351,100	$365			$351,465	0.910	$319,834	$23.13	0.82	$18.87
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$68,349,496	$45,398	$947,498	($72,288)	$69,270,104			$5,151.01		$4,274.83
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$5,255.17		$5,020.88

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
Rural	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$7,624	$5		$821	$8,450	1.073	$9,069	$0.57	0.82	$0.47
Ambulatory Surgery Center	$20,524	$17			$20,542	1.025	$21,050	$1.33	0.82	$1.09
Case Management Services	$1,855	$2			$1,856	1.025	$1,902	$0.12	0.82	$0.10
Consumer Directed Services	$7,187,284	$437	$10,892	$143,888	$7,342,501	1.287	$9,447,137	$597.80	0.82	$487.80
DME/Supplies	$1,758,991	$1,828		($92,009)	$1,668,811	0.910	$1,518,621	$96.10	0.82	$78.41
Emergency	$939,454	$2,458			$941,912	1.072	$1,009,944	$63.91	0.82	$52.15
FQHC	$234,076	$198			$234,275	1.025	$240,067	$15.19	0.82	$12.40
Home Health Services	$950,438	$2,487			$952,925	1.072	$1,021,752	$64.65	0.82	$52.76
Inpatient - Medical/Surgical	$14,119,934	$13,396		$294,550	$14,427,879	0.954	$13,770,037	$871.34	0.82	$711.02
Inpatient - Psych	$16,882	$0		($712)	$16,170	0.954	$15,433	$0.98	0.82	$0.80
Lab and X-ray Services	$560,146	$582		($67,287)	$493,441	0.910	$449,032	$28.41	0.82	$23.19
Medicare Xover - IP	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - OP	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Other	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Physician	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Nursing Facility	$23,943,232	$11,678	$770,942	$1,867,748	$26,593,601	0.951	$25,282,003	$1,599.80	0.82	$1,305.44
Outpatient - Other	$4,107,960	$10,750			$4,118,709	1.072	$4,416,194	$279.45	0.82	$228.03
Outpatient - Psychological	$0	$0			$0	1.072	$0	$0.00	0.82	$0.00
Personal Care Services	$5,678,697	$1,073	13753.4679	$113,869	$5,807,393	1.081	$6,278,294	$397.28	0.82	$324.18
Physician - Clinic	$1,066,960	$904		$5,478	$1,073,342	1.025	$1,099,878	$69.60	0.82	$56.79
Physician - IP Mental Health	$3,293	$3		$17	$3,312	1.025	$3,394	$0.21	0.82	$0.18
Physician - OP Mental Health	$1,943,559	$1,646		$42,176	$1,987,381	1.025	$2,036,516	$128.87	0.82	$105.16
Physician - Other Practitioner	$800,307	$678		$4,649	$805,634	1.025	$825,552	$52.24	0.82	$42.63
Physician - PCP	$1,534,228	$1,300		$8,913	$1,544,440	1.025	$1,582,624	$100.15	0.82	$81.72
Physician - Specialist	$1,105,578	$936		$6,422	$1,112,937	1.025	$1,140,452	$72.17	0.82	$58.89
Pharmacy	$9,935,894	$512		($3,322,327)	$6,614,079	1.044	$6,902,631	$436.79	1.00	$436.79
Transportation - Emergency	$556,508	$578			$557,086	0.910	$506,949	$32.08	0.82	$26.18
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$76,473,425	$51,470	$795,588	($993,805)	$76,326,677			$4,956.25		$4,133.36
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$5,056.44		$4,854.44

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
Tidewater	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$20,349	$13		$2,191	$22,553	1.073	$24,206	$1.48	0.82	$1.21
Ambulatory Surgery Center	$26,633	$23			$26,656	1.025	$27,315	$1.67	0.82	$1.36
Case Management Services	$0	$0			$0	1.025	$0	$0.00	0.82	$0.00
Consumer Directed Services	$1,907,299	$116	$149	$38,129	$1,945,694	1.287	$2,503,402	$152.95	0.82	$124.81
DME/Supplies	$1,815,300	$1,887		($94,954)	$1,722,233	0.910	$1,567,235	$95.75	0.82	$78.14
Emergency	$1,294,632	$3,388			$1,298,020	1.072	$1,391,773	$85.03	0.82	$69.39
FQHC	$141,015	$119			$141,134	1.025	$144,623	$8.84	0.82	$7.21
Home Health Services	$929,587	$2,433			$932,019	1.072	$999,337	$61.06	0.82	$49.82
Inpatient - Medical/Surgical	$12,827,613	$12,170		$267,591	$13,107,374	0.954	$12,509,740	$764.32	0.82	$623.68
Inpatient - Psych	$95,432	$0		($4,026)	$91,406	0.954	$87,238	$5.33	0.82	$4.35
Lab and X-ray Services	$539,412	$561		($64,797)	$475,176	0.910	$432,411	$26.42	0.82	$21.56
Medicare Xover - IP	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - OP	$13	$0			$13	1.000	$13	$0.00	1.00	$0.00
Medicare Xover - Other	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - Physician	$20	$0			$20	1.000	$20	$0.00	1.00	$0.00
Nursing Facility	$31,425,414	$15,328	$2,186,408	$2,451,414	$36,078,564	0.951	$34,299,167	$2,095.61	0.82	$1,710.02
Outpatient - Other	$3,092,128	$8,092			$3,100,219	1.072	$3,324,141	$203.10	0.82	$165.73
Outpatient - Psychological	$0	$0			$0	1.072	$0	$0.00	0.82	$0.00
Personal Care Services	$13,417,949	$2,536	47438.3466	$269,356	$13,737,280	1.081	$14,851,187	$907.38	0.82	$740.42
Physician - Clinic	$1,591,111	$1,348		$8,170	$1,600,628	1.025	$1,640,201	$100.21	0.82	$81.77
Physician - IP Mental Health	$600	$1		$3	$604	1.025	$619	$0.04	0.82	$0.03
Physician - OP Mental Health	$3,842,867	$3,255		$83,391	$3,929,514	1.025	$4,026,665	$246.02	0.82	$200.75
Physician - Other Practitioner	$1,256,845	$1,065		$7,301	$1,265,211	1.025	$1,296,491	$79.21	0.82	$64.64
Physician - PCP	$1,536,842	$1,302		$8,928	$1,547,072	1.025	$1,585,321	$96.86	0.82	$79.04
Physician - Specialist	$1,233,319	$1,045		$7,165	$1,241,528	1.025	$1,272,223	$77.73	0.82	$63.43
Pharmacy	$9,286,038	$479		($3,105,031)	$6,181,486	1.044	$6,451,165	$394.15	1.00	$394.15
Transportation - Emergency	$468,316	$487			$468,803	0.910	$426,611	$26.07	0.82	$21.27
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$86,748,736	$55,644	$2,233,996	($125,170)	$88,913,206			$5,476.45		$4,549.99
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$5,587.25		$5,344.60

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
All Regions	Medicaid Payments FY13 - FY14	Completion Factor Adjustment	Patient Payments FY13 - FY14	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY16	Managed Care Utilization Adjustment	PACE PMPM FY16
Service Type										
Adult Day Care	$711,407	$470		$72,849	$784,726	1.073	$842,231	$12.52	0.82	$10.22
Ambulatory Surgery Center	$85,263	$72			$85,335	1.025	$87,445	$1.30	0.82	$1.06
Case Management Services	$1,855	$2			$1,856	1.025	$1,902	$0.03	0.82	$0.02
Consumer Directed Services	$24,127,831	$1,466	$18,714	$482,677	$24,630,688	1.287	$31,690,768	$471.11	0.82	$384.43
DME/Supplies	$6,944,653	$7,219		($363,258)	$6,588,614	0.910	$5,995,651	$89.13	0.82	$72.73
Emergency	$4,265,097	$11,161			$4,276,258	1.072	$4,585,121	$68.16	0.82	$55.62
FQHC	$511,176	$433			$511,609	1.025	$524,258	$7.79	0.82	$6.36
Home Health Services	$3,263,942	$8,541			$3,272,483	1.072	$3,508,846	$52.16	0.82	$42.56
Inpatient - Medical/Surgical	$59,840,560	$56,772		$1,248,307	$61,145,638	0.954	$58,357,689	$867.54	0.82	$707.91
Inpatient - Psych	$286,467	$0		($12,084)	$274,383	0.954	$261,872	$3.89	0.82	$3.18
Lab and X-ray Services	$2,295,667	$2,386		($275,766)	$2,022,287	0.910	$1,840,285	$27.36	0.82	$22.32
Medicare Xover - IP	$1,184	$0			$1,184	1.000	$1,184	$0.02	1.00	$0.02
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.00	$0.00
Medicare Xover - OP	$13	$0			$13	1.000	$13	$0.00	1.00	$0.00
Medicare Xover - Other	$456	$0			$456	1.000	$456	$0.01	1.00	$0.01
Medicare Xover - Physician	$29	$0			$29	1.000	$29	$0.00	1.00	$0.00
Nursing Facility	$119,413,619	$58,245	$5,954,467	$9,315,141	$134,741,471	0.951	$128,096,014	$1,904.26	0.82	$1,553.87
Outpatient - Other	$15,163,317	$39,680			$15,202,997	1.072	$16,301,073	$242.33	0.82	$197.74
Outpatient - Psychological	$0	$0			$0	1.072	$0	$0.00	1.00	$0.00
Personal Care Services	$39,365,086	$7,441	$78,158	$789,005	$40,239,690	1.081	$43,502,583	$646.70	0.82	$527.71
Physician - Clinic	$5,752,859	$4,873		$29,538	$5,787,270	1.025	$5,930,351	$88.16	0.82	$71.94
Physician - IP Mental Health	$10,413	$9		$53	$10,476	1.025	$10,735	$0.16	0.82	$0.13
Physician - OP Mental Health	$11,722,144	$9,929		$254,374	$11,986,447	1.025	$12,282,792	$182.59	0.82	$149.00
Physician - Other Practitioner	$4,665,727	$3,952		$27,104	$4,696,783	1.025	$4,812,903	$71.55	0.82	$58.38
Physician - PCP	$6,443,569	$5,458		$37,432	$6,486,459	1.025	$6,646,826	$98.81	0.82	$80.63
Physician - Specialist	$5,165,484	$4,375		$30,007	$5,199,866	1.025	$5,328,425	$79.21	0.82	$64.64
Pharmacy	$38,615,667	$1,990		($12,912,163)	$25,705,494	1.044	$26,826,945	$398.81	1.00	$398.81
Transportation - Emergency	$1,967,977	$2,046			$1,970,022	0.910	$1,792,724	$26.65	0.82	$21.75
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$47.22	1.00	$47.22
Total	$350,621,462	$226,517	$6,051,339	($1,276,785)	$355,622,533			$5,387.47		$4,478.25
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								$5,496.46		$5,260.20

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

Virginia Medicaid

Exhibit 5a

FY 2016 PACE Capitation Rate Development
Summary of FY 2016 Capitation Rates
Before Nursing Home vs Non-Nursing Home Blending Factor Adjustment

Region	Dual Eligibles FY 2016	Non-Dual Eligibles FY 2016	Weighted Average FY 2016	Difference from UPL Rates
		PACE Rates		
Northern Virginia	$4,325.62	$6,051.28	$4,484.18	-5.7%
Other MSA	$3,557.95	$5,165.97	$3,663.54	-5.6%
Richmond/Charlottesville	$3,541.05	$5,020.88	$3,675.73	-5.6%
Rural	$3,110.75	$4,854.44	$3,232.94	-5.6%
Tidewater	$3,547.75	$5,344.60	$3,741.54	-5.6%
Statewide Average weighted by PACE Eligibles	$3,545.92	$5,243.50	$3,688.24	-5.6%

Region	Dual Eligibles FY 2016	Non-Dual Eligibles FY 2016	Weighted Average FY 2016
		UPL	
Northern Virginia	$4,593.05	$6,338.38	$4,753.41
Other MSA	$3,776.73	$5,388.68	$3,882.57
Richmond/Charlottesville	$3,759.10	$5,255.17	$3,895.26
Rural	$3,301.59	$5,056.44	$3,424.56
Tidewater	$3,766.20	$5,587.25	$3,962.59
Statewide Average weighted by PACE Eligibles	$3,764.17	$5,481.93	$3,908.18

Note:
Percent change and weighted average by region based on historical member months for PACE eligibles.

Virginia Medicaid

Exhibit 5b

FY 2016 PACE Capitation Rate Development
Historical Fee-For-Service Claims
Nursing Home vs Non-Nursing Home Blending Factor

Dual Population

Region	Cost		Statewide	
	%NH of Avg	%Non-NH of Avg	NH Blending Weight	Blend Factor
Northern Virginia	1.28	0.76	54.5%	1.0414
Other MSA	1.34	0.40	54.5%	0.9123
Richmond/Charlottesville	1.41	0.52	54.5%	1.0008
Rural	1.46	0.48	54.5%	1.0161
Tidewater	1.23	0.73	54.5%	1.0001

Non-Dual Population

Region	Cost		Statewide	
	%NH of Avg	%Non-NH of Avg	NH Blending Weight	Blend Factor
Northern Virginia	1.51	0.66	40.0%	0.9977
Other MSA	1.66	0.49	40.0%	0.9605
Richmond/Charlottesville	1.83	0.54	40.0%	1.0567
Rural	1.67	0.61	40.0%	1.0361
Tidewater	1.37	0.70	40.0%	0.9678

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Comparison of Capitation Rates
Before and After Blending Factor Adjustment

Exhibit 5c

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	Before Blending	After Blending	% Change	Before Blending	After Blending	% Change	Before Blending	After Blending	% Change
					PACE Rates				
Northern Virginia	$4,325.62	$4,504.64	4.1%	$6,051.28	$6,037.37	-0.2%	$4,484.18	$4,645.47	3.6%
Other MSA	$3,557.95	$3,246.02	-8.8%	$5,165.97	$4,961.73	-4.0%	$3,663.54	$3,358.68	-8.3%
Richmond/Charlottesville	$3,541.05	$3,543.92	0.1%	$5,020.88	$5,305.72	5.7%	$3,675.73	$3,704.26	0.8%
Rural	$3,110.75	$3,160.81	1.6%	$4,854.44	$5,029.48	3.6%	$3,232.94	$3,291.76	1.8%
Tidewater	$3,547.75	$3,548.18	0.0%	$5,344.60	$5,172.38	-3.2%	$3,741.54	$3,723.34	-0.5%
Statewide Average weighted by PACE Eligibles	$3,545.92	$3,531.07	-0.4%	$5,243.50	$5,286.45	0.8%	$3,688.24	$3,678.23	-0.3%
Statewide Average weighted by PACE Enrollees*	$3,511.95	$3,489.12	-0.7%	$5,243.50	$5,266.86	0.4%	$3,641.65	$3,622.28	-0.5%

Note:
Percent change and weighted average by region based on historical member months for PACE eligibles.
*Statewide weighted average based on February 2015 PACE Enrollees.

Virginia Medicaid

Exhibit 5d

FY 2016 PACE Capitation Rate Development
Summary of FY 2016 Capitation Rates
After Nursing vs Non-Nursing Home Blending Factor Adjustment

Region	Dual Eligibles FY 2016	Non-Dual Eligibles FY 2016	Weighted Average FY 2016	Difference from UPL Rates
		PACE Rates		
Northern Virginia	$4,504.64	$6,037.37	$4,645.47	-5.7%
Other MSA	$3,246.02	$4,961.73	$3,358.68	-5.6%
Richmond/Charlottesville	$3,543.92	$5,305.72	$3,704.26	-5.6%
Rural	$3,160.81	$5,029.48	$3,291.76	-5.6%
Tidewater	$3,548.18	$5,172.38	$3,723.34	-5.6%
Statewide Average weighted by PACE Eligibles	$3,531.07	$5,286.45	$3,678.23	-5.6%
Statewide Average weighted by PACE Enrollees*	$3,489.12	$5,266.86	$3,622.28	-5.6%

Region	Dual Eligibles FY 2016	Non-Dual Eligibles FY 2016	Weighted Average FY 2016
		UPL	
Northern Virginia	$4,783.13	$6,323.81	$4,924.70
Other MSA	$3,445.61	$5,175.64	$3,559.21
Richmond/Charlottesville	$3,762.16	$5,553.30	$3,925.17
Rural	$3,354.71	$5,238.76	$3,486.74
Tidewater	$3,766.65	$5,407.20	$3,943.58
Statewide Average weighted by PACE Eligibles	$3,748.41	$5,523.88	$3,897.26
Statewide Average weighted by PACE Enrollees*	$3,703.86	$5,506.43	$3,838.88

Note:
Percent change and weighted average by region based on historical member months for PACE eligibles.
*Statewide weighted average based on February 2015 PACE Enrollees.

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Comparison of FY 2015 and FY 2016 Capitation Rates

Exhibit 5e

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	FY 2015	FY 2016	% Change	FY 2015	FY 2016	% Change	FY 2015	FY 2016	% Change
					PACE Rates				
Northern Virginia	$4,443.28	$4,504.64	1.4%	$6,075.03	$6,037.37	-0.6%	$4,593.21	$4,645.47	1.1%
Other MSA	$3,236.66	$3,246.02	0.3%	$5,141.87	$4,961.73	-3.5%	$3,361.76	$3,358.68	-0.1%
Richmond/Charlottesville	$3,509.79	$3,543.92	1.0%	$5,535.68	$5,305.72	-4.2%	$3,694.16	$3,704.26	0.3%
Rural	$3,103.97	$3,160.81	1.8%	$5,161.34	$5,029.48	-2.6%	$3,248.14	$3,291.76	1.3%
Tidewater	$3,501.12	$3,548.18	1.3%	$5,256.48	$5,172.38	-1.6%	$3,690.43	$3,723.34	0.9%
Statewide Average weighted by PACE Eligibles	$3,488.39	$3,531.07	1.22%	$5,417.38	$5,286.45	-2.42%	$3,650.12	$3,678.23	0.77%
Statewide Average weighted by PACE Enrollees*	$3,447.95	$3,489.12	1.19%	$5,405.30	$5,266.86	-2.56%	$3,594.56	$3,622.28	0.77%

Note:
Percent change and weighted average by region based on historical member months for PACE eligibles.
*Statewide weighted average based on February 2015 PACE Enrollees.

Virginia Medicaid
FY 2016 PACE Capitation Rate Development
Member Months of Eligibles and Enrollees

Exhibit 5f

PACE Eligibles, Historical Member Months FY 2013 - FY 2014

Region	Dual Eligibles	Non-Dual Eligibles	Total
	Member Months		
Northern Virginia	115,483	11,684	127,167
Other MSA	136,388	9,585	145,972
Richmond/Charlottesville	138,119	13,829	151,948
Rural	209,709	15,803	225,512
Tidewater	135,398	16,367	151,765
Statewide Average	735,097	67,268	802,365

PACE Enrollees, February 2015

Region	Dual Enrollees	Non-Dual Enrollees	Total
	Member Months		
Northern Virginia	60	9	69
Other MSA	155	7	162
Richmond/Charlottesville	295	30	325
Rural	201	10	211
Tidewater	450	38	488
Statewide Average	1,161	94	1,255

Virginia Medicaid — Exhibit 6

FY 2016 PACE Capitation Rate Development
Historical Fee-For-Service Claims
Description of Unit Counts

Service Type	Type of Units
Adult Day Care	Units
Ambulatory Surgery Center	Units
Case Management Services	Units
Consumer Directed Services	Hours
DME/Supplies	Claims
Emergency	Claims
FQHC	Units
Home Health Services	Claims
Inpatient - Medical/Surgical	Admits
Inpatient - Psych	Days
Lab and X-ray Services	Claims
Medicare Xover - IP	Admits
Medicare Xover - Nursing Facility	Days
Medicare Xover - OP	Claims
Medicare Xover - Other	Claims
Medicare Xover - Physician	Claims
Nursing Facility	Days
Outpatient - Other	Claims
Outpatient - Psychological	Claims
Personal Care Services	Units
Pharmacy	Scripts
Physician - Clinic	Units
Physician - IP Mental Health	Units
Physician - OP Mental Health	Units
Physician - Other Practitioner	Units
Physician - PCP	Units
Physician - Specialist	Units
Transportation - Emergency	Claims
Transportation - Non-Emergency	N/A

Virginia Medicaid

FY 2016 PACE Capitation Rate Development
Historical Fee-for-Service Claims
County Listing by Region

Exhibit 7

Northern Virginia	Other MSA	Richmond/Charlottesville	Rural		Tidewater
Alexandria City	Amherst County	Albemarle County	Accomack County	Lexington City	Chesapeake City
Arlington County	Appomattox County	Amelia County	Alleghany County	Lunenburg County	Gloucester County
Clarke County	Bedford City	Caroline County	Augusta County	Madison County	Hampton City
Fairfax City	Bedford County	Charles City County	Bath County	Martinsville City	Isle of Wight County
Fairfax County	Botetourt County	Charlottesville City	Bland County	Mecklenburg County	James City County
Falls Church City	Bristol City	Chesterfield County	Brunswick County	Middlesex County	Mathews County
Fauquier County	Campbell County	Colonial Heights City	Buchanan County	Northampton County	Newport News City
Fredericksburg City	Craig County	Cumberland County	Buckingham County	Northumberland County	Norfolk City
Loudoun County	Danville City	Dinwiddie County	Buena Vista City	Norton City	Poquoson City
Manassas City	Franklin County	Fluvanna County	Carroll County	Nottoway County	Portsmouth City
Manassas Park City	Frederick County	Goochland County	Charlotte County	Orange County	Suffolk City
Prince William County	Giles County	Greene County	Clifton Forge City	Page County	Surry County
Spotsylvania County	Harrisonburg, City of	Hanover County	Covington City	Patrick County	Virginia Beach City
Stafford County	Lynchburg City	Henrico County	Culpeper County	Prince Edward County	Williamsburg City
Warren County	Montgomery County	Hopewell City	Dickenson County	Rappahannock County	York County
	Pittsylvania County	King and Queen County	Emporia City	Richmond County	
	Pulaski County	King William County	Essex County	Rockbridge County	
	Radford, City of	Louisa County	Floyd County	Russell County	
	Roanoke City	Nelson County	Franklin City	Shenandoah County	
	Roanoke County	New Kent County	Galax City	Smyth County	
	Rockingham County	Petersburg City	Grayson County	Southampton County	
	Salem City	Powhatan County	Greensville County	Staunton City	
	Washington County	Prince George County	Halifax County	Tazewell County	
	Winchester, City of	Richmond City	Henry County	Waynesboro City	
		Sussex County	Highland County	Westmoreland County	
			Lancaster County	Wise County	
			King George County	Wythe County	
			Lee County	Scott County	

Scott County is in Other MSA for Medallion 3.0 rate setting, but is moved to Rural for PACE rate setting.
Bedford County is in Roanoke-Alleghany for Medallion 3.0 rate setting, but is retained in Other MSA for PACE rate setting.